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ABSTRACT

This document contains witness testimonies and prepared statements from the Congressional hearing called to investigate ways of minimizing routine and catastrophic health care costs for the elderly. Recent changes in both the costs and quality of health care are examined. Opening statements are included from Congresswoman Helen Delich Bentley and from Congressmen Thomas J. Tauke, Jim Lightfoot, and Ben Blaz. Five panels of witnesses provide testimony. Panel One consists of Sally Folkoff and Mr. Nikaliades, both children of Medicare beneficiaries; Bonnie McLaughlin, Meridian Nursing Home Center; and Colleen Galambos, Stella Maris Hospice. Panel Two consists of three physicians: William Reichel, Jose Martinez, and Ross Pierpont. Panel Three consists of Kevin Moley from the United States Department of Health and Human Services. Panel Four consists of witnesses from the insurance industry, including Howard Richmond, Chief Investigator, Life and Health, Maryland Insurance Division; Joseph La Asmar, Chesapeake Health Plan; and Gary L. Eng, Blue Cross and Blue Shield of Maryland. The Fifth Panel includes Barbara B. Hill, Johns Hopkins Health Plan; Patrick Mattingly, Wyman Park Health Plan; and Catherine Kilmurray, American Association of Retired Persons. Materials submitted for the record are included throughout the text. (NB)

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INVESTIGATION ON WAYS OF MINIMIZING ROUTINE AND CATASTROPHIC HEALTH COSTS FOR THE AGING

HEARING

BEFORE THE

SUBCOMMITTEE ON
RETIREMENT INCOME AND EMPLOYMENT

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

APRIL 21, 1986, ESSEX, MD

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INVESTIGATION ON WAYS OF MINIMIZING ROUTINE AND CATASTROPHIC HEALTH COSTS FOR THE AGING

MONDAY, APRIL 21, 1986

House of Representatives,
Select Committee on Aging,
Subcommittee on Retirement Income and Employment,
Essex, MD.

The subcommittee met, pursuant to notice, at 9 a.m., in the Essex Community College Lecture Hall, Essex, MD, Hon. Helen Delich Bentley (acting chairwoman of the subcommittee) presiding.

Members present: Representatives Bentley, Tauke, Lightfoot, and Blaz.

OPENING STATEMENT OF CHAIRWOMAN HELEN DELICH BENTLEY

Mrs. Bentley. Good morning, I am Congresswoman Helen Delich Bentley, representing the Second Congressional District of Maryland, and I want to take this opportunity to thank the president of the Essex Community College for all the preparations that they have made for this hearing today. There is a lot of work involved in one of these hearings and Essex Community College has really put itself out to give us the best of everything. We do appreciate it.

I also want to welcome all of you here today to this hearing put on by the Select Committee on Aging. All of the four people you see up here are members of the Select Committee on Aging. We will be joined a little later by Congressman Rinaldo, who will be driving down from New Jersey.

The purpose of today's hearing is to investigate ways of minimizing routine and catastrophic health care costs for the elderly. Today we will be looking into the problems that senior citizens are having with out-of-pocket health care costs.

We want to investigate recent changes in both the costs and quality of the health care world. What were the costs seniors pay in out-of-pocket health care costs before Medicare was enacted in 1965, and how much are they paying now? Has the gap widened? If so, how can we contain the future cost of health care for seniors? These are the questions that need to be answered, and today we are going to get these answers.

In the past 5 years, older Americans and their families have suffered continued cutbacks in health and social programs. Added to this is the recent move toward balancing the budget. Are the cuts being made by the Federal Government today detrimental to many seniors?

Why are out-of-pocket health care costs increasing annually?

Can the elderly afford to pay more in out-of-pocket health care costs expenses? Can the Federal Government?

If this trend of budget cutting continues, what will happen to the quality of health care Americans receive?

In the recent past, we have turned to the idea of health maintenance organizations. Are these organizations doing what they were intended to do? Are they minimizing health care costs? If not, what is the next step?

Should we place caps on hospitals and doctors, or is there a need for increased Federal funding, even if it means a tax increase?

It is time to face the facts. In 1965 the Medicare Program was enacted by Congress to provide insurance protection for older people against the costs of health care. Today, because of gaps in coverage, Medicare is paying a smaller portion of the average seniors health bill. Gaps include no coverage for eyeglasses, dental care, hearing aids, organ transplants, and most nursing home and in-home care.

As we will see today, these gaps present problems. A Massachusetts based study by Harvard Medical School and Massachusetts Blue Cross/Blue Shield reported that 63 percent of elderly persons living alone will impoverish themselves after only 13 weeks in a nursing home. For elderly married couples, 37 percent will become impoverished within 13 weeks if one spouse requires nursing home care. This situation is deplorable and demands immediate attention. We can't allow the elderly to bear the brunt of health care loopholes.

I would now like to welcome my distinguished colleagues: Congressman Rinaldo, as I said, the ranking minority member of the Select Committee on Aging, will be joining us. Congressman Tauke, ranking minority member of the Subcommittee on Retirement, Income and Employment; Congressman Lightfoot, and Congressman Blaz. All have devoted much time and interest to the issues that we are about to address here today. Gentlemen, I thank you for your attendance today. I will let each of our distinguished colleagues give an opening statement for this hearing.

STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Mr. Tauke. Thank you very much, Helen, ladies and gentleman.

It gives me a great deal of pleasure to be able to come to Maryland this morning to meet with you in the district of our friend and colleague, Helen Bentley. As Helen indicated, I serve on the Aging Committee, but I also have a seat on the House Subcommittee on Health. From that position I have an opportunity to look at the health care programs that affect our Nation, and in my position on the Aging Committee, I have an opportunity to review those programs, especially as they affect the elderly.

I just want you to know that your Representative in Congress, Helen Bentley, has been most interested in all of these issues that affect the elderly, but especially the impact of health care costs upon elderly citizens. In my work on both the Health Subcommittee and the Aging Committee, I have found her to be an invaluable resource in providing information about the impact of some of the changes that are being made in Medicare and in the health delivery system upon senior citizens in Maryland, and frankly, in Iowa and across the rest of the Nation.

We do have some serious problems in the delivery of health care services to the elderly and the rising costs of health care is certainly a vital concern to elderly citizens all across our Nation. That concern was underscored recently with the report that the Medicare hospital deductible will rise to $572 next year. That is increasing from $492 this year.

When the increase took place this year to $492, the experts in the bureaucracy told us this is a one time deal, it won't happen again. Now the report comes out and says $572 for next year. Beneficiaries are obviously worried about the coverage that they do not have and so they are concerned not only about the deductible but what other gaps there might be in the coverage. So, consequently, we have a number of senior citizens purchasing various health care policies.

Some citizens have purchased three, four, and five health care insurance policies advertised by one of our TV movie stars on TV. We find that this kind of thing suggests that we have two problems:

One, a lack of resources for the elderly to meet their needs.

Two, a great deal of confusion about what Medicare will and will not cover.

Health spending for those over age 65 averaged about $4,200 per person in 1984, the last year for which we have statistics. Two-thirds of that bill was picked up by public programs, but one-third was paid by the elderly or their families either directly to providers or indirectly through premiums. That certainly has made this a major issue for senior citizens and others.

But perhaps beyond just that statistic is the reality that many elderly citizens are concerned that they will be unable to afford to purchase health services if they should have an extended health care problem, and I guess it is that problem of catastrophic health care that is foremost in our minds this year in Congress, and it is an issue that we hope we can address. But even if we are successful in addressing the catastrophic health care issue, we still have many major issues before us to address as we try to figure out how to fashion a health care system that lives within the budgetary constraints which are a reality now for our Nation, but at the same time, doesn't leave many senior citizens either going without health insurance in some instances, or otherwise having inadequate health care coverage for their needs.

So, Helen, I want to thank you for inviting me this morning and we look forward to what apparently will be an excellent hearing, looking at the list of witnesses you have compiled.

[The prepared statement of Representative Tauke follows:]

PREPARED STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Chairwoman Bentley, I commend you for convening this hearing on a subject of vital importance to the nation's elderly—the rising cost of health care. The recent announcement that the Medicare deductible for hospitalization may rise to $572 dollars next year, after having already taking a staggering leap up from $400 to $492 this year, underlines both the subject and the importance of this hearing. The information my colleagues and I receive here today will help to shape our consideration of legislative alternatives for ensuring that the elderly have access to high-quality, affordable health care services.

Health spending for people aged 65 and older is considerable. In 1984, it averaged $4,200 per person. Public health care programs such as Medicare and Medicaid paid two-thirds of this bill, but over one-third was paid by the elderly or their families in direct payments to health care providers and in indirect payments through premiums.

But statistics alone do not reveal the burden of these costs. They take an emotional and physical toll on the elderly, as well. The elderly do not wish to be dependent upon their families for care, but they know that a catastrophic illness requiring lengthy hospitalization or care in a nursing home could well drain not only their resources, but their spouses' and children's too. Because they cannot afford deductibles and copayments on their limited means, many elderly do not seek health care until an illness is in an advanced stage. Many elderly simply cannot afford the high cost of prescriptions. So they do without or reduce their dosages to make the medicine last longer, again jeopardizing their health.

Twenty years ago, Congress sought to ensure that the elderly had access to high-quality, affordable health care services by establishing the Medicare program. With the implementation of this program, the federal government became the major direct purchaser of health care services in the nation...and in part due to the program's cost-based reimbursement system, health care costs began to rise steadily, outpacing general inflation, and soaring into double-digit figures in the late 1970s and early 1980s. In 1967, Medicare cost the federal government $3.2 billion. In 1985, the cost was $70 billion.

Pressed by a staggering deficit and the threat that the Medicare trust funds would be insolvent within several years, Congress enacted a number of Medicare reforms in reimbursement to providers. The program's growth has been slowed, but insolvency again threatens. And in focusing so intensely on cost, we have not paid enough attention to continuing to ensure the quality of services Medicare beneficiaries are receiving and their access to services. This year, Medicare beneficiaries, on the average, are likely to pay out a slightly greater percentage of their income for health care services than they did when Medicare was implemented.

Every year, proposals are introduced to expand traditional Medicare coverage to reduce these out-of-pocket costs by covering eyeglasses and routine eye exams, dental care, prescriptions, and other needs. While we recognize the burden that these and other costs place on the elderly, we cannot expand the program—we are constrained by the budget deficit and by the impending insolvency of the Medicare trust fund.

While beneficiaries support and would welcome such additional coverage, they are more concerned about maintaining the value of the coverage they have. They are concerned that when they need hospitalization now, they may not be admitted or will be admitted only after a wait while someone in a distant city decides if their illness meets certain guidelines. They are concerned that they will be discharged before they are well and able care for themselves or be cared for in another setting.

And every year, beneficiaries worry that the benefits they now have will be reduced and premiums and deductibles increased because of the overriding concern about the budget. It is the budget, frankly, that is now dictating Medicare policy. We do what we can, but every increase in one area must be offset with savings in others.

If we had it to do over again, would establishing Medicare in its current form—the federal government directly purchasing health care services and dictating which types of services all beneficiaries may receive—be the route we'd choose to ensure that all beneficiaries have access to high-quality, affordable health care services? I do not think so.

In 1985, following several years of promising demonstration projects, all Medicare beneficiaries were given the option of enrolling in HMOs for their full Medicare coverage if a Medicare-qualified HMO was available. While there have been some problems with this new option, and while great care must be taken to ensure that quality of care is maintained, providing this option was a step in right direction. To attract plan members, many HMOs are offering more comprehensive coverage than is available under the traditional Medicare program. Routine preventive services are provided, helping the elderly to retain their health. Many plans also cover eyeglasses, hearing aids, and dental care services, as well as other services for which the elderly must now bear the cost.

Beneficiaries now have a choice, an option. They are freer now to choose among coverage alternatives, selecting the type of coverage most appropriate to their health care needs.

I will shortly be introducing legislation to expand upon this step and provide protection to the elderly against catastrophic health care costs while freeing their health care coverage from the shadow of the deficit. Under my proposal, Medicare and Medicaid beneficiaries could opt for vouchers, set initially at the worth of their traditional coverage and ultimately at the average of qualified plan premiums in their area, with which to purchase qualified health insurance coverage.

To qualify, an insurance plan or provider arrangement would have to provide at least as much basic health care coverage as does the current Medicare program. In addition, the out-of-pocket costs of plan members would be capped, providing protection against catastrophic illness.

Competition for vouchers will provide incentives to plans to offer more comprehensive coverage. The option that Medicare voucher users would have to change plans on a yearly basis should help to ensure quality of care.

A voucher plan, in my view, offers the most promising alternative for ensuring that this nation's elderly have access to high-quality, affordable health care services and are freed from the emotional, physical, and financial threat of rising out-of-pocket costs. I realize that such a plan must be carefully structured to ensure quality, and I am looking forward to today's testimony, as I am sure I will gain many insights into refinements I should include in my proposal.

Thank you for your attention to my comments.

Mrs. BENTLEY. Thank you very much.

Congressman Lightfoot.

STATEMENT OF REPRESENTATIVE JIM LIGHTFOOT

Mr. LIGHTFOOT. Thank you, Helen.

I am glad to be here today in Congresswoman Bentley's district to examine ways to minimize routine and catastrophic health care costs for older Americans. This is an important topic not only to the people of Maryland, but for people all across the Nation, and I commend Mrs. Bentley for organizing this hearing today.

I would like to basically echo my colleague, Mr. Tauke's comments as to some of the things that are happening. We live in a State, in fact in my district, where almost 20 percent of the people in the district are over the age of 65. Our State, I think, ranks fourth in the Nation, with a number of people over the age of 65. Health care to our citizens is very, very important to us, as it is to you folks here in Maryland, and I think we have to guard against the budgetary cuts that are being made so that we don't jeopardize the quality of health care. We are finding that is a reality in some areas.

As Tom mentioned, a lot of people are being sold a lot of different kinds of policies. My dad, for example, is 77, and we had dinner out at the farm yesterday, and of course, in the farm country the salesman drives into your driveway. He had three people in the last week trying to sell him some kind of a health care package. He is pretty bullheaded. He told them to hit the road because he already had something. Nevertheless, we see that type of thing going on, which is an indication that there is maybe a problem.

No. 2, there is always a possibility some of those people may be trying to take advantage of folks at the same time.

I look forward to hearing from you folks who volunteered to come testify this morning. We are going to have a good hearing.

And Helen, again I compliment you on putting this hearing together, and I look forward to the hearing today.

[The prepared statement of Representative Lightfoot follows:]

PREPARED STATEMENT OF REPRESENTATIVE JIM LIGHTFOOT

I AM GLAD TO BE HERE TODAY IN CONGRESSWOMAN BENTLEY'S DISTRICT TO EXAMINE WAYS TO MINIMIZE ROUTINE AND CATASTROPHIC HEALTH CARE COSTS FOR OLDER AMERICANS. THIS IS AN IMPORTANT TOPIC -- NOT ONLY FOR THE PEOPLE OF MARYLAND, BUT FOR PEOPLE ALL ACROSS THE NATION -- AND I COMMEND MRS. BENTLEY FOR ORGANIZING THIS HEARING.①

ALTHOUGH MRS. BENTLEY AND I REPRESENT DISTRICTS IN DIFFERENT PARTS OF THE COUNTRY, WE SHARE SOME COMMON PROBLEMS -- THAT IS ENSURING THAT OUR NATION'S SENIORS RECEIVE ACCESSIBLE, AFFORDABLE, AND ADEQUATE HEALTH CARE SERVICES. AS THE MEDICARE SYSTEM EXPERIENCES FINANCIAL DIFFICULTIES AND AS OUR NATION'S POPULATION CONTINUES TO GROW OLDER, WE MUST WORK TO PROVIDE FOR A MORE COST-EFFECTIVE HEALTH CARE SYSTEM. BUT, ON THE SAME TOKEN, WE MUST NOT SACRIFICE QUALITY OF CARE FOR OUR NATION'S ELDERLY.

WITH THIS IN MIND, I LOOK FORWARD TO HEARING FROM OUR WITNESSES TODAY. I HOPE THEY CAN GIVE US SOME GOOD IDEAS WITH WHICH WE CAN SHARE WITH OUR COLLEAGUES ON WAYS TO IMPROVE OUR HEALTH CARE SYSTEM WITHOUT INCREASING THE COSTS TO OLDER AMERICANS.

CONGRESSWOMAN BENTLEY, THANK YOU ONCE AGAIN FOR INVITING ME TO YOUR HEARING.

Mrs. **Bentley**. Thank you.

I was interested in the comment that 25 percent of your constituency is 65 years or older. We are running a very close second to you here in Baltimore County.

Congressman Blaz.

STATEMENT OF REPRESENTATIVE BEN BLAZ

Mr. **Blaz**. Thank you very much, Helen.

I made a deal with Helen that if I came 100 miles from the Capital to attend this hearing she would go 10,000 miles to Guam. So if she is not here in January next year, it is because she is in my warm climate in Guam.

I am here for a couple of reasons:

One, because there is a very interesting thing in the Congress—if there is one thing that we agree upon in the Congress it is the problems of the aging population. It transcends all political parties, all ages, all ethnic groups, and all walks of life.

Interestingly enough, in my community, which is the doorstep of Asia, the elderly is venerated to some high degree. We don't have the problems that you all have here. I see them coming on the horizon, however, as we adapt to the ways of our society, that is, the American society on Guam.

Right now we don't even have a rest home on Guam, as an example. We don't have any place where you could send for health care, it is taken care of by the families. You might not think there is a community in America that is like that now, and there is—called Guam. So I am very interested in the happenings here because I see we are going to be faced with some of the same problems.

I am also here because I am an aging person, as you can see. I have a vested interest. I want to know what you all have in mind for later, because I intend to take advantage of the opportunities.

But above all, I want to congratulate and recommend Helen Bentley for having the hearing in the first place. Her stature in Congress is such that when Helen Bentley asks you to do something, you do it, because she is also in a position, and frequently offers her own assistance. It isn't every day you run across a person like her. For that reason, when most members are traveling on a Monday getting back to the Capital, we came on in Sunday so we would be here on Monday morning. This is the tribute that we have for this fine lady who represents you.

I am looking forward to the hearing and to doing what I can, as a member of this committee myself, to bring about better health care, better health maintenance for our aging population.

Thank you.

Mrs. **Bentley**. Thank you, Ben.

I would like to point out that Congressman Blaz is also a retired Marine brigadier general, so he has been very active in many fields.

Our first panel this morning consists of four persons who are directly affected by health care, two of them whose families have been affected by Medicare and the treatment—we will hear their stories. Then the other two persons are people dealing with the elderly. We will call out their names first, then we will start in that rotation.

Sally Folkoff who is the daughter of a Medicare beneficiary; Mr. Nikaliades, who is the son of a Medicare beneficiary; Bonnie McLaughlin, who is representing Melanie Cox from the Meridian Nursing Home Centers; and Colleen Galambos, from Stella Maris Hospice.

PANEL ONE: CONSISTING OF SALLY FOLKOFF, DAUGHTER OF A MEDICARE BENEFICIARY; MR. NIKALIADES, SON OF A MEDICARE BENEFICIARY; BONNIE McLAUGHLIN, REPRESENTING MERIDIAN NURSING HOME CENTER; AND COLLEEN GALAMBOS, STELLA MARIS HOSPICE

STATEMENT OF SALLY FOLKOFF

Ms. **Folkoff**. Good morning. I am here today on behalf of my stepfather, Samuel Shapos, a 78-year-old widowed resident at Meridian Nursing Center in Randallstown. In early November he had episodes of what his doctors call bunches of small strokes." This previously friendly, helpful man exhibited such unacceptable, antisocial, bizarre behavior that nurses-aides/companions were required on 12-hour daily shifts to prevent him from annoying and disrupting other residents and harming himself. Until tests could be made, results studied, and confirming diagnosis made, this was the only way to protect and control him. These 12-hour daily shifts of aides, frequent visits by his physicians required for adjusting and supervising medications and for consultations, all had to continue.

Because he had not required hospitalization, most of these costs were not covered by any of his medical insurance. The Medicare supplement insurance, for which regular payments have been maintained, covered none of the costs of physicians' services, tests, x rays, scans, or the nurses aid/companions.

Obviously, the fact that he did not require hospitalization, which would have been very costly, meant only one thing—no hospital, minimal coverage. This supplement covers nothing because he is in a nursing home and was not sent there from a hospital, even though he has required ongoing medical care and the additional care needed as a result of this medical condition.

How would this have been handled; what would have happened to him if he had not had some small financial reserve? As a result, his funds have been depleted and now his care is being covered by medical assistance. When he was well and able to, he was very proud to be able to take care of himself, to pay his own way, so to speak.

The costs for this time were $4,588, of which he paid $3,590; Medicare paid $510, Blue Shield $66.84. The doctor's adjusted their fees by $412. The Medicare supplement paid nothing.

Mrs. **Bentley**. Thank you.

Mr. Nikaliades.

STATEMENT OF MR. NIKALIADES

Mr. **Nikaliades**. Congressman, coming a long way from Guam, we appreciate your being here and I think that what you are doing is a tremendous asset to the Nation. This is a problem that really needs addressing and the fact that you are willing to address it speaks on behalf of your courage and determination in this field. I want to commend each and every one of you.

I don't have the story that the young woman on my left over here espoused just a moment ago. My father is 90 years old. He was recently released from Johns Hopkins Hospital, and for the past month, he is receiving custodial care, which he needs very badly. He can't get around like he used to. He really needs someone to take care of him continuously.

Mrs. **Bentley**. Is he in his own house?

Mr. **Nikaliades**. Yes; and this is the dignity that I would like for you to look at when we are speaking about care for the elderly. He is in his own house. He is able, with the care that he is getting from the Visiting Nurses Association, and then I pay for a woman to come in on Fridays and give him custodial care that is $8 an hour, for a minimum of 3 hours. Now, if he didn't have this care from the Visiting Nurses Association, to monitor him, it would run into the hundreds and hundreds of dollars every week.

I have recently been told that Medicare is running out and they are going to be able to continue just a bit longer, but then it is over because even though he hasn't improved, they told him how to take his medicine. Now what happens if this man doesn't take his medicine? He is 90 years old, as I said, if someone doesn't oversee this.

Now, I have been able to help him up to now, but I have got two kids in college and another one in Calvert Hall. It is going to be a burden. It is not only going to be a burden on me; my father only makes $358 from Social Security. If he has to pay for where he is going to go to, what happens? Do we leave this man, that has been proud all of his life and who has been able to take care of himself? He has asked nothing from no one. How many years does he have?

Finally, the Government is able to do something for him. Does it mean to discard him at this point in life? I don't know, but I think your committee should address those questions and I know that is what you are here to determine, and in my closing remarks, I want to again thank you, but I would want you to look at this problem of custodial care especially. That is what concerns me at the present time, but I know what the previous speaker said concerns her even more.

So thank you, Mrs. Bentley, and gentlemen, for giving me this opportunity to say these few words.

Mrs. **Bentley**. Both types of care are very important for the elderly.

Ms. McLaughlin is from the Meridian Nursing Home Centers.

STATEMENT OF BONNIE McLAUGHLIN

Ms. **McLaughlin**. I will be giving testimony on behalf of Melanie Cox, corporate director of nursing for Meridian Health Care, a private corporation that owns and operates 27 long-term care facilities in 4 States, totaling almost 4,000 beds. My purpose today is to share with you the impact of limited reimbursement by third-party payors on some of our residents. Presently our company average of Medicare residents or other insurance is less than 2 percent. This figure is skewed as is any average, with some facilities having up to 18 percent of their residents under Medicare and some have none.

Problems for residents could be classified into three categories: lack of knowledge as to coverage with Medicare; the financial impact of copay; and the cost of high technology equipment once the maximum 100 days are utilized.

Lack of knowledge applies to the health care professionals as well as the residents and families. Qualification criteria for skilled services in long-term care are quite rigid and limiting. The expectation is if you need nursing home care then Medicare will pay. Unfortunately, this is no place close to the reality of the types of conditions that do qualify for coverage.

In addition, now with the elimination of the waiver system facilities are going to be less apt to cover a questionable care because their insurance in the waiver system no longer exists. Unmet expectations leads to anger and frustration for residents and families who are already faced with anxiety and fear as to their future.

Once a person qualifies for Medicare in many situations this means a limit of 21 days despite the issue of qualification because of the dollar amount involved in copay. Presently the copay amount approaches the average room rate. Consequently, what we see is a person being discharged after 21 days when the continuation of therapy, for example physical therapy, for another 2 weeks under the same therapist and in the same surroundings would increase the recovery rate.

Any relocation rate results in a decrease in functioning. Relocation before adequate stabilization can severely retard progress. In one recent case a woman with multiple sclerosis in physical therapy for a fractured hip, left after 21 days for financial reasons. The therapist felt strongly she needed at least 2 more weeks before trying to go home. The husband was taught how to care for her and therapy at home was arranged. However, the second day home the wife, while going to the bathroom, lost her balance and both the husband and wife fell, resulting in the wife being readmitted to the hospital, and the husband feeling guilty that he had not been able to care for his wife adequately.

There are various treatment modalities that cannot be corrected within 100 days. In this age of high technology the numbers and types of such treatments will only increase. Two of the most common types of high technology long-term therapies today are hyperalimentation and clinitron therapy. There are many cases where these therapies have been discontinued after the 100 days of Medicare coverage resulting in deteriorating conditions of residents soon thereafter.

There was a resident with a decubitus ulcer on clinitron therapy that was healing and with an additional 30 days of therapy, would have healed completely. Medicare had elapsed and the family could not pay the additional $75 per day for the therapy in addition to all the other costs, including room rate and supplies. Within 2 weeks of discontinuation of clinitron therapy the ulcer was back to its original stage IV advanced stage, and the resident died 2 months later of general systemic reaction to the ulcer.

Compare this case to another where the woman not only had an ulcer but also pathological factures from metastic cancer of the brain. She had private insurance that covered long-term care and she remained on clinitron therapy which reduced her pain and fracture potential for 5 months until she died at age 48. At least her family knew she had all resources available to make her as comfortable as possible during those last difficult months.

As we admit these and other more acutely ill residents from acute care facilities, these examples are going to grow. This is not a potential issue. It is one that exists today and is only going to worsen. We must address it now and make some difficult decisions if we are going to prepare for the future.

Mrs. **Bentley**. Thank you.

Ms. Galambos from Stella Maris Hospice.

STATEMENT OF COLLEEN GALAMBOS

Ms. **Galambos**. I welcome this group that is going to look at this issue.

I think Stella Maris is in a unique position in that we not only provide long-term care, but also a home and care program, so I can address both of those concerns.

I am Colleen Galambos, director of social work and outreach at the Cardinal Shehan Center for the Aging, and president of the National Association of Social Workers, Maryland chapter, which represents 2,400 social workers in the State.

I wish to comment on the inadequacies of Medicare and Medicaid reimbursement of health care costs for the elderly, and suggest ways in which to effectively reduce out-of-pocket health care costs for this population.

Recent deductions in Medicare have reduced expenditures in hospital costs. However, older persons who are hospitalized find themselves frequently being discharged earlier and in poorer health. At the same time, other Medicare-funded programs, such as home health care and nursing home care have been limited and constrained. As a result, many recently discharged, ill, older persons are not receiving adequate health care.

The realities that patients are being discharged quicker and sicker have placed new demands on skilled nursing facilities and home health care systems. The crisis that aged, infirm Medicare patients face after a hospital stay is that most do not require a level of care that permits Medicare nursing home coverage. Skilled nursing services are required and custodial care is not reimbursable, even if an individual is unable to function independently within the community.

Consider the case of Mrs. J who was recovering from a CVA. She did not require ongoing rehabilitation, but had generalized weakness. She had no skilled need, but required assistance in preparing meals and shopping. She could not afford an attendant and did not qualify for a level of care—which prohibited nursing home placement. She had no community supports or family. Two weeks later, she was admitted back into the hospital for severe dehydration.

Medicare coverage for nursing home care does not cover total costs. At the Cardinal Shehan Center, on the average, Medicare pays for only 2 percent of the total number of nursing home days charged and the patient is responsible for the remainder of the costs.

Many elderly would prefer to recover from hospital care in their own home. There have been reductions in this area, even though home health care is less expensive and leads to rapid recovery. Congress has permitted Medicare coverage of home health care services provided there is an intermittent need, the patient is home bound, and skilled nursing services are required. Due to varying interpretations of the word intermittent, home health care services have been limited in terms of the number of persons who should receive it, and the period of time in which the care is provided.

In addition, Medicare does not pay for nursing aide services without a skilled service, even if it meets the patient's needs and would prevent future hospitalizations. Many elderly persons on fixed incomes cannot afford to pay for custodial care in the home.

There have been numerous reports of patients being discharged prematurely, or to settings that were inappropriate, due to the prospective payment system. There is little regard for a patient's individual social situation, or community support system.

Consider this case: Mr. A, age 75, was discharged from the hospital because his DRG limitations were up, and he needed to be placed in the community. He had surgery for a double amputation of his legs. He was delivered by an ambulance to his trailer home, put in a wheelchair and left. Mr. A lived alone, could not transfer out of his wheelchair, and could not leave his trailer because it was not handicap accessible. Protective Services was contacted by the neighbors, and he was able to be maintained in the community through the use of nursing aides until a social worker arranged for admission into a rehabilitation hospital, where he learned to transfer and use his protheses.

Medicare also does not provide coverage for prescriptions, physicians office visits, medical equipment, and some medical supplies. The older person, on a fixed income of $450 a month cannot pay for their rent, food, and medical expenses, nor are they eligible for public assistance. Many do without necessary medical supplies. The proposed $5 copayment charge for home health care services would place an additional financial overburden on this population. It is my belief that people would deny themselves care as a result of this.

Finally, many elderly cannot pay the $492 part A Medicare deductible required each time they enter hospitals as inpatients. Those too poor to purchase private insurance coverage to supplement Medicare are affected most drastically by this cost.

Many of the same problems with Medicare coverage are found in Medicaid coverage. Hospitalized elderly are being discharged earlier and in a needier state. Home Medicare coverage is inadequate to meet the needs of the patient, particularly in the areas of rehabilitation and social work services.

Reimbursement for nursing home care is inadequate to meet the costs of providing care to medical assistance recipients. At the Cardinal Shehan Center, Stella Maris, 55 percent of our residents are recipients of medical assistance. We are reimbursed for only 75 percent of our costs per Medicaid patient. Many small and proprietary nursing homes will not admit medical assistance patients due to this poor reimbursement. This reduces access to needed services for low-income aged.

Finally, Medicaid will not cover needed services and equipment. Eyeglasses may only be obtained every 2 years, even though an older person's eyesight may change more rapidly. Physical therapy for maintenance purposes is not covered. There is a one time only coverage for many medical equipment items. Consider this example:

Mrs. P, age 70, had both of her legs amputated. She was waiting for both of her stumps to heal before she could use protheses. She lived in a small, unsafe rowhouse. She depended on her wheelchair for ambulation. One evening there was a fire. Mrs. P was saved because a neighbor rushed in and carried her out of the house. Everything else was destroyed, including her wheelchair. Medical assistance denied supplying her with another wheelchair, stating that she had received her allotted one. As a result, the woman remained on her sister's couch, unable to move, until a wheelchair was donated to her. This took 4 weeks to occur.

In summary, I would like to make several suggestions to reduce out-of-pocket health care costs to the elderly:

One, roll back the Medicare part A deductible to more affordable levels.

Two, assure access to appropriate high quality post hospital care such as nursing home and home health care programs by increasing reimbursement in these areas.

Three, reject the $5 copayment proposal for home health care services.

Four, provide additional coverage for prescriptions, medical equipment, and medical supplies.

Five, increase community-based programs such as meals on wheels, homemaker services, personal care programs, and sheltered housing, which provides assistance to the frail, ill elderly and helps them to remain in the community.

Finally, the fiscal year 1987 budget should assume no net reduction in Federal expenditures for health. In addition, the President's proposal to reduce Federal Medicaid spending should be rejected. If we do not begin to meet the needs of this frail elderly population, then this country will truly face a crisis within health care delivery similar to the crisis of deinstitutionalized mentally ill.

Mrs. BENTLEY. Thank you.

We will now have questions of the panel.

Mr. Nikaliades, I believe you mentioned that you are paying or your father is paying $8 an hour for each visit that the visiting nurses make?

Mr. NIKALIADES. No, there was another agency. It was another agency. They come in and clean and give personal care. So that charge is $8 an hour and with the minimum of 3 hours. So we have to bear that.

Mrs. BENTLEY. Do you also have the free visiting nurse care, too?

Mr. NIKALIADES. Yes; I do. That is what enables him to get along at home. If I didn't have the visiting nurses that meant I would have to have three more times a week that he would have to pay or I would have to pay.

Mrs. BENTLEY. Which would be impossible to afford at this point for you?

Mr. NIKALIADES. That is right.

Mrs. **Bentley**. Your father is very alert and normal mentally?

Mr. **Nikaliades**. He is quite capable. He is very alert, 90 years old, has got a mind that is better than mine.

Mrs. **Bentley**. God bless.

I think this custodial care, which Ms. Galambos discussed also is very, very important and it is something that this committee needs to get.

Mr. **Nikaliades**. I believe that in the name of analysis, it would be much cheaper than keeping someone either in a hospital or the other types of programs that the Government would have to pay for. This would enable the person to stay in his own home and I think the cost would be much cheaper there.

Mrs. **Bentley**. Ms. Galambos, do you have any idea how many cases or persons that your hospice accommodates in a month or how many you help?

Ms. **Galambos**. We have 401 beds. In addition to that, we have an Outreach Program.

Mrs. **Bentley**. It is the Outreach Program I am asking about.

Ms. **Galambos**. We outreach over 100 people per year, plus we have a waiting list. In addition to that, we do have elderly housing units and I think in total, counting all of the elderly housing facilities, there are 300 residents.

Mrs. **Bentley**. I am personally familiar with some of those that you have handled in their homes and I know how appreciative the families were that they were able to stay home during their terminal illness and the help that they got from your people in the hospice program.

Ms. McLaughlin, you mentioned about the lack of knowledge about Medicare availability and lack of knowledge by the family. You touched on those one right after the other. Would you go into a little more about the lack of knowledge and what can be done about educating people and informing?

Ms. **McLaughlin**. Certainly there have been efforts to educate the public, but evidently they have not been very successful. Time after time, in looking at patients for admission, the family says we have Medicare and you know they are misled into thinking Medicare is going to cover all of these services, when in fact Medicare is not going to cover these services. Certainly they are upset and disheartened that this is not the case and that they may not have funds available to them, it is just very frustrating for them.

Mrs. **Bentley**. I will turn the questioning over to Mr. Tauke now.

Mr. **Tauke**. Thank you, Madam Chairman.

Ms. Galambos, you indicated in your example I think of an individual who seemed to be discharged from a hospital perhaps before he should have been. In fact you suggested that his DRG had expired so therefore he was discharged. As I am sure you know, it is illegal for the hospital to do that simply because the DRG has expired, but we continue to hear reports of this kind of thing happening.

In your experience, are people being discharged from hospitals prematurely, and do you think that they are aware of their rights as patients to be maintained in a hospital until they are in a position where they are able to leave?

Ms. **Galambos**. I think that people are being discharged prematurely. I do not believe that the average American realizes their rights.

Mr. **Tauke**. You indicate that it was the hospital that delivered this individual to his home, his trailer?

Ms. **Galambos**. Yes. Well, an ambulance company that was contracted by the hospital.

Mr. **Tauke**. No provision was made ahead of time for any kind of ongoing care. I guess this is what astonishes me. Sometimes we think we don't have the greatest care in certain areas of my district, but I have never heard of a hospital doing something like this. Is this a customary kind of problem?

Ms. **Galambos**. I think that it happens. I don't know how often it happens. With this particular case, the point is that if the man had been able to pay for his custodial care, he would have been able to be maintained within the community. Certainly living alone and not being able to get around, he was in danger.

Mr. **Tauke**. You had a number of suggestions about what could be done, some of them were very good. Obviously they carry a fairly stiff price tag as well. I wonder if any of the other people on the panel have any observations about a couple of things.

First of all, do you think that it would make sense to tie Medicare benefits to some kind of need analysis in order to be able to give those who need the benefits a greater number of benefits, while at the same time, not providing benefits perhaps to those who are more financially well off?

Ms. **Galambos**. That is certainly something to look at. We get many people applying to Stella Maris very, very able to afford their care. Others are destitute, so I know that there is a portion of the elderly population able to provide for themselves, but I am concerned about the middle class, the people who worked hard all of their life, 40-hour work weeks, didn't make a lot of money, and here they are elderly and they cannot afford care, and they do not qualify for public assistance, so they are caught right in the middle.

Mr. **Tauke**. Anybody else have any reaction to the needs testing Medicare?

One more question. I am not familiar with what the State of Maryland does in Medicaid. Does the State supplement the Federal Medicaid or does the State simply rely on the minimal levels that the Federal Government mandates for the State, do you know?

Ms. **Galambos**. I am not really an appropriate person to ask that question.

Mr. **Tauke**. I am sure someone on the later panels will be able to tell us.

Thank you.

Mrs. **Bentley**. Mr. Lightfoot.

Mr. **Lightfoot**. Thank you, Madam Chairman.

I would like to have Ms. Galambos follow up on Mr. Tauke's question about people being dismissed before they should be. The perception in our part of the country is that we have a lot of problems getting people admitted that need to be under the DRG system. Do you see that as a problem here? I will give you a quick example:

I was talking to a doctor on Saturday, who has an elderly gentleman as a patient, who has a bleeding ulcer at this point, but the people in Des Moines don't like the way the paperwork was filled out so they won't let him put this man in the hospital. I think it is utterly ridiculous. Are you finding that here as well?

Ms. Galambos. It is interesting that you bring that up, because we just had a case 2 weeks ago where a friend called from someone in the community saying this person needed immediate placement within our facility. We are not able to handle that kind of request, but I was concerned about the urgency on the other end of the line, and I asked our medical director to please give a physical examination to this man in the community, and it turns out that he needed hospitalization. He was hospitalized.

Two weeks prior to being seen by the medical director, he had been seen by a physician, and at that point his medical condition was not bad enough to warrant admission to the hospital.

Mr. Lightfoot. Part of the problem we are seeing with it is how to phrase the conditions to be exactly what is happening so that the review system will allow patients to go into a hospital. The people are more interested in the paperwork being filled out than they are the condition of the patient, and many times the doctors are seeking approval from a secretary who has no medical experience whatsoever, and it is up to some secretary to decide whether this individual goes in the hospital or not. Is that a problem here? I see your head shaking.

Ms. McLaughlin. Certainly. This is something that I have some real concerns about. I have talked recently through association meetings with a lot of nurse friends of mine, that are working home health, and they are all very concerned about these same issues, that you meet criteria for admission according to set guidelines for a particular DRG so that hospital is assured payment.

In addition, for that particular DRG you are going to be limited to *x* amount of days and although maybe it could be debatable whether or not the patient was ready for discharge, some nurses that are working with some of these patients in the home feel that they have been prematurely discharged.

Recently one was telling me about an elderly gentleman who had bilateral cataracts removed and a cab was called and he was sent home with no arrangements made for care. So yes, I have a lot of concerns. From my perspective being in long-term care, we are certainly seeing patients coming to us, very, very ill, but that is not affecting us as far as caring for them, as far as some of these patients being sent back into the community without provisions being made.

Mr. Lightfoot. This was one of the concerns. As Tom mentioned earlier, we don't see quite as many people being turned out in our county as maybe the testimony has reflected here this morning. Some of that may be because we are smaller counties, everybody knows everybody, and that elderly patient is probably a friend of somebody in the hospital or at least somebody on the staff. But the other side of the coin is that once the DRG runs out, the only way the care facility has a means of recouping those costs is tacking it on my bill or your bill, so we are paying for it and through taxes, paying for it again in terms of higher costs when we have to go to the hospital.

Would it be a fair statement then that not only are we causing people to come to the hospital sicker but they are also leaving sicker?

Ms. **McLaughlin**. Most definitely.

Mr. **Lightfoot**. I see four heads shaking.

Mr. **Nikaliades**. That seems to be the logical conclusion.

Mrs. **Bentley**. Mr. Blaz.

Mr. **Blaz**. Thank you.

Ms. Folkoff, both of you mentioned the tragedy of watching two individuals lose their self-confidence, self-respect and just shattered because of the way that they are being unable to maintain them properly and unless you watch this it must be awfully frustrating to you. I was wondering, this is in a home situation, when you are looking at them it must be very difficult for you, knowing that this may be a preview of a coming attraction for yourself?

Mr. **Nikaliades**. Yes.

Mr. **Blaz**. Or distraction, whatever the word is.

In the hospice and in the center situation for Ms. McLaughlin and Ms. Galambos, do you see the same type of thing happening to patients when they do not receive the care? In other words, they break down more than physically but probably psychologically and mentally as well?

Ms. **McLaughlin**. I am not sure I heard the question correctly.

Mr. **Blaz**. I didn't phrase it correctly, that is probably the reason. Besides you are the only Irish lady. What happened to your name?

I was struck by the mention of the fact that in caring for the sick at home, in addition to the financial burden on the families watching a person, a proud person, delapidate, deteriorate mentally and psychologically because of inadequacy of everyone to provide the proper care. This is very obvious at home. I was wondering in the public arena, where you both work, do you witness the same thing happening to the patients there as well?

For instance, in your situation, there is a 2 percent of Medicare, just 2 percent, paid by Medicare, so the burden is very heavy on the families as well. So, my question specifically is, Do you witness the same kind of frustration that happens to——

Ms. **McLaughlin**. Certainly there is a frustration. I don't think that we are probably experiencing the same kinds of frustrations that maybe you see in the community because you if someone is being admitted to us there is some sort of payment and they are going to be receiving care, but you are going to be seeing the frustration and concern of financial draining, the impact on the families, the concern, as I think you mentioned, for their future, for everyone's future and where is this all going to end?

This is something that we are hearing over and over again in talking to families. There is a great deal of anxiety manifested not only by the illness that they are dealing with with their family member, but their concerns, personal concerns about health care in the future. Of course, whether or not it is going to be something that is affordable.

Mr. **Blaz.** Thank you. Thank you. It must be very courageous for you to say some of these things you do.

Mrs. **Bentley.** I want to thank these four panelists who have given us very hands on examples, emphasizing the importance and need of doing something about providing better financial aid for the elderly in their illnesses.

Thank you very much for coming.

Our next panel will be the medical panel. In the problems of health care, sometimes we hear some criticisms of the doctors, along with the hospitals, but we have here this morning three doctors who have devoted a lot of their energies to helping the elderly in particular, and have contributed a great deal to excellent medical care in the Baltimore area and I particularly want to welcome them.

Dr. Reichel, William Reichel, chairman of the Department of Family Practice of Franklin Square, who is in Baltimore, and who when we started to organize this, we were talking about who do we get to testify and right away, his name popped up. He has written a great deal—I will give him the names of three of his textbooks—"Clinical Aspects of Aging," "Geriatric Patients," and "Topics in Aging and Long Term Care." He is a member of the editorial board of the "American Family Physicians and Family Practice."

When I was asking the Dr. Reichel who do we get in the HMO who knows a lot about it, he immediately said Dr. Jose Martinez, who is an expert in it, and so we are very happy to have Dr. Martinez join us today. He is from from the Department of Medical Affairs, Health Care Corp. of the Mid-Atlantic.

And Dr. Ross Pierpont, who I think everybody knows in the area, who is considered probably one of the best surgeons anywhere, and who has been very active in providing the best care and one of the top men at Maryland General Hospital, and other places.

So we will start off this morning, Dr. Reichel, with you and your statement.

PANEL TWO: CONSISTING OF DR. WILLIAM REICHEL, CHAIRMAN, DEPARTMENT OF FAMILY PRACTICE, FRANKLIN SQUARE HOSPITAL, BALTIMORE, MD; DR. JOSE MARTINEZ, DIRECTOR, DEPARTMENT OF MEDICAL AFFAIRS, HEALTH CARE CORP. OF THE MID-ATLANTIC, BALTIMORE, MD; AND DR. ROSS PIERPONT, CHIEF OF SURGERY, MARYLAND GENERAL HOSPITAL, BALTIMORE, MD

STATEMENT OF DR. WILLAIM REICHEL

Dr. **Reichel.** As I received the letter from your staff that said to discuss the benefits/drawbacks for doctors belonging to an HMO as opposed to not being in one, and that sort of startled me. More than the benefits and drawbacks for doctors, I am concerned what the benefits and drawbacks for patients are—and my own model of care—in my written statement I described the attributes of care which I consider important. The rebirth of family medicine brings back many of these attributes of care, continuity of care. One physician taking care of somebody over a period of time, and physicians serving as an integrator of care, as looking at the entire picture, being at the helm, a coordinator, administrator of care, compassion and communication skills.

These are aspects of care which have been sliding in the past and the rebirth of family medicine, which is the old general practitioner, has really emphasized these attributes and these strengths of medicine which I think are part of the excellence of care. And what concerns me about HMO's—and I am sure there are attributes to HMO's—is the chief attributes or purpose of HMO's is to protect health maintenance, wellness, excellence in care, or the purpose simply to reduce costs?

The concerns I have are about the patients: how the patients will do in the HMO, what do HMO's do about the personal bond between doctor and patient? Is there one person in charge? What happens to the personal bond, what happens to the continuity of care? Continuity of care is so important. It is vital over a period of time, one physician stay and listen to that patient and his family, that so long as that physician is practicing, he is or she is still there to take care of that patient and family.

It can be a period of 20 to 30 years of time that they know the person. That is their cost savings from knowing them, they know them personally, this family. There is a certain way it could avoid certain tests, certain unnecessary tests and hospitalizations by that knowledge. So that is why I think continuity is so important and that that personal bond and trust is so important.

If that can exist in the HMO's I think that is good. But I think that is the standard that we should be measuring by, measuring the degree of continuity of care in the system, and by the personal bond that takes place between the doctor and patient. If there are lack of these attributes, then in the newly evolved HMO's and GPPO's, there is a serious deficiency in the system.

[The prepared statement of Dr. Reichel follows:]

PREPARED STATEMENT OF DR. WILLIAM REICHEL, CHAIRMAN, DEPARTMENT OF FAMILY PRACTICE, FRANKLIN SQUARE HOSPITAL, BALTIMORE, MD.

Regarding the matter of health care expenses, I am enclosing three items from the Journal of the American Medical Association (JAMA).

1. A Commentary from JAMA entitled "The Future of Family Medicine in Response to Demographic Changes and Increasing Specialization," dated March 18, 1983.

2. An Editorial from JAMA, entitled "The Continuity Imperative," dated November 6, 1981.

3. A Letter to the Editor from Dr. F. Peter Rescigno from Glen Ridge, New Jersey, dated March 21, 1986. This letter deals with Health Maintenance Organizations (HMO's).

Regarding the matter of health care expenses, both the Commentary and Editorial from JAMA refer to seven attributes of the specialty of Family Medicine in the year 2000. Because of the increasing numbers of elderly and also because of increasing specialization and subspecialization, the family physician will be called upon to provide care based on the following attributes and contributions of Family Medicine or Family Practice as a specialty:

1. The role of the family physician as the integrator of the biopsychosocial model. With increasing subspecialization and technology, there will be greater demands and societal pressures to have a family physician at the helm, a physician who can understand, integrate, coordinate, and administer health care of an individual and his or her family. The narrower the scope of various subspecialty skills and practices, the greater demand there will be for an integrator in clinical care, teaching and research.

2. The comprehensive practice of the family physician. The comprehensiveness, versatility, portability, and flexibility of the family physician's practice allows the family physician to meet a wide range of human needs.

3. The continuity imperative. With an increasingly older population, and with increasing specialization and technology, the cost implications of care will become greater, and there will be more and more recognition of the value of continuity of care by a family physician or other primary care physician. There will be recognition of the value of having a deeper knowledge of the patient and his circumstance. There is a real value in having the same physician staying closely in touch with the patient and family, whether the patient is in the office, home, general hospital, long-term care facility, cancer center, or other environments of care.

4. Concern for the entire family. The physician caring for the elderly should be concerned about means to bolster the family unit. Strengthening the family and building additional support systems is a critical step in solving many of our problems, for example, avoidance of expensive and unnecessary institutionalization in the care of the elderly. The lack of day care centers is one example of a deficiency in our system which works against a family being able to take care of its impaired family member at home.

5. The role of the family physician in complex, ethical decision-making. In the year 2000, we will be faced with difficult and ambiguous choices and decisions of an ethical nature. In the family physician's role as integrator and administrator, he or she must utilize compassion, common sense, and an ability to deal with complex, ethical issues. The family physician will be called on to make more and more complex decisions according to the accepted traditions and values of his or her religion, nation, and society or culture.

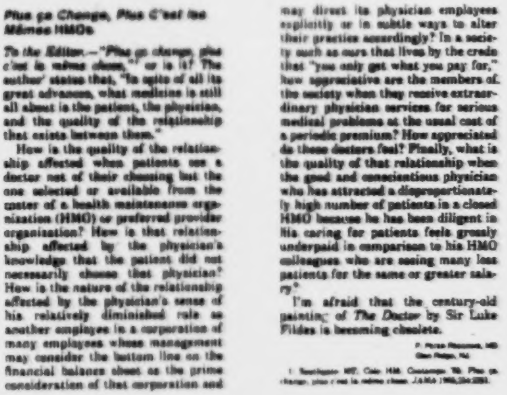
6. The role of the family physican in prevention. The family physician in the future will place a major emphasis on disease prevention and optimal health. By the year 2000, we will certainly know a great deal more that can be applied in daily practice.

7. Compassion and humanism in the daily practice of Family Medicine. Surpassing our specialized knowledge or new technical skills at the present time or in the year 2000 is a need to express compassion, humanism, warmth, and empathy. It is important that we remember that "the secret of care of the patient is caring for the patient." The specialty of Family Practice places the highest value on the understanding of the doctor-patient relationship and certain essential communication skills.

The special attributes and contributions of Family Medicine are outlined in the enclosed 1981 Editorial and 1983 Commentary in JAMA. It is possible for HMO's to include this type of thinking in their development. HMO's are using family physicians more and more because of the need for comprehensiveness and versatility of skills, and because of the value of having an integrator of care at the helm, someone who can coordinate and administer health care and also serve as a gatekeeper.

However, I must share with you my major concerns about HMO's. Is the main purpose of Health Maintenance Organizations and Preferred Provider Organizations to promote health maintenance, wellness, and excellence in care, or is the main purpose simply to reduce cost? Some important concerns are expressed in the Letter to the Editor from Dr. F. Peter Rescigno of Glen Ridge, New Jersey, in the March 21, 1986 issue of JAMA. Dr. Rescigno points to a number of weaknesses of HMO's which clearly exist. Most of these have to do with the issue of the personal bond between the doctor and the patient.

Therefore, I can support HMO's if they allow the attributes of Family Medicine and the other best qualities of our American health care system to flourish. If the HMO or PPO system allows these qualities, then the health care provided will be excellent. If there are breaks in continuity of care, with the lack of a clear cut primary care physician who knows and understands the patient and family, then this is disturbing. It is disturbing if a personal bond cannot develop between the doctor and patient and the patient's family. It is the personal bond that characterizes the highest standard of care. Excellent health care in America should be measured by the degree of continuity of care in the system, and by the personal bond between doctor and patient. If there are a lack of these attributes in the newly evolving HMO's and PPO's, then this represents a serious deficiency in our system.



Plus ça Change, Plus C'est les Mêmes HMOs

To the Editor.—"*Plus ça change, plus c'est la même chose*,"[1] or is it? The author[1] states that, "In spite of all its great advances, what medicine is still all about is the patient, the physician, and the quality of the relationship that exists between them."

How is the quality of the relationship affected when patients see a doctor not of their choosing but the one selected or available from the roster of a health maintenance organization (HMO) or preferred provider organization? How is that relationship affected by the physician's knowledge that the patient did not necessarily choose that physician? How is the nature of the relationship affected by the physician's sense of his relatively diminished role as another employee in a corporation of many employees whose management may consider the bottom line on the financial balance sheet as the prime consideration of that corporation and may direct its physician employees explicitly or in subtle ways to alter their practice accordingly? In a society such as ours that lives by the credo that "you only get what you pay for," how appreciative are the members of the society when they receive extraordinary physician services for serious medical problems at the usual cost of a periodic premium? How appreciated do these doctors feel? Finally, what is the quality of that relationship when the good and conscientious physician who has attracted a disproportionately high number of patients in a closed HMO because he has been diligent in his caring for patients feels grossly underpaid in comparison to his HMO colleagues who are seeing many less patients for the same or greater salary?

I'm afraid that the century-old painting of *The Doctor* by Sir Luke Fildes is becoming obsolete.

F. Peter Rescigno, MD
Glen Ridge, NJ

1. [illegible] Plus ça change, plus c'est la même chose. JAMA [illegible]

The Future of Family Medicine in Response to Demographic Changes and Increasing Specialization

IN 15 years, we will enter the next millenium. I want to refer to two major changes occurring that will deeply affect medical practice in the year 2000. First are the demographic changes taking place throughout the world with an increasingly elderly population; second is the increasing use of technology in medicine.

In the year 1900, 4% of the population in the United States were 65 years or older. At the present time, 11.3% are older than 65 years. Various projections exist for the year 2000. It is likely that 12.2% of the American population in the year 2000 will be older than 65 years. By the year 2020, those older than 65 years will constitute 15.6% of the population and, by the year 2025, 18.3%. An increasingly older population is being seen throughout the world, including in nations of Asia, South America, and Africa.

The other important phenomenon is the increasing specialization and technical nature of medical practice. Every year in the United States, we are seeing new accomplishments in medical technology. Computed tomography, computerized nuclear medicine, achievements in intensive care and critical care, achievements in hemodialysis, and achievements in cardiovascular surgery are all becoming part of our everyday medical environment.

With the two assumptions of a greater proportion of older citizens and increasing subspecialization and technology, what can we say about medical care? I want to point out seven characteristics of family medicine in the future.

The Role of the Family Physician as the Integrator of the Biopsychosocial Model

With increasing subspecialization and technology, there will be greater demands and societal pressures to have a family physician at the helm, a physician who can understand, integrate, coordinate, and administer health care of an individual and his or her family. The narrower the scope of various subspecialty skills and practices, the greater demand there will be for an integrator in clinical care, teaching, and research.

The discipline of family medicine owes George Engel a debt of gratitude for his role in describing a biopsychosocial model.[1] Family medicine as it is evolving is a specialty that attempts to deal with the full scope of genetic, environmental, psychological, social, cultural, and family factors in patient care over time. In looking at the whole organism and his environment, family medicine is best able to avoid a reductionist point of view.

Thus, the family physician is an integrator or administrator. In the United States, our hospital administrators play a similar role. They may not have the same depth of knowledge or skill in each of the many functions of the modern hospital. A hospital administrator will not know as much about finances or data processing or food service or cardiology or purchasing or engineering as each of the department heads of these divisions. However, the overall management of the hospital is left to the hospital administrator. In our hospitals it would be a mistake for any single department to operate autonomously. Similarly, it is a mistake if the patient is seen only from the viewpoint of the specialist or subspecialist.[2] The individual will not have the best of health care if he or she is seen from a single specialty viewpoint without the full understanding of other organ systems, information based on follow-up or continuity over a period of time, emotional or psychological factors, and knowledge of the family and community.

This ability to understand and integrate all aspects of the biopsychosocial model requires training. The family physician of the present and future must be trained in this skill. Understanding the full picture, the patient's totality, will lead to the best possible decision making. In intelligently recommending any treatment plan, it is important to understand the patient's other physical and emotional problems, knowledge of home environment, family constellation, availability of friends, access to transportation, and patient's economic situation.

The integrative role of the family physician is important not only in clinical care and teaching, but has enormous potential in research as well. In the United States, each family practice residency training program has a family practice center as a main source of training in that residency. Family practice centers and other large family practice offices contain ideal populations for longitudinal studies of human growth, development and aging, and disease patterns within a relatively normal population. The populations in the family practice centers are more heterogeneous than most patient populations in the United States. The research implications of this capability have not been fully appreciated.

The Comprehensive Practice of the Family Physician

In being trained as the integrator or administrator of the biopsychosocial model, it is important that the family physician have the knowledge and skills to practice in a comprehensive fashion. The comprehensiveness, versatility, portability, and flexibility of the family physician's practice allow the family physician to meet a wide range of human needs. In the ideal health care model of the future, the family physician will have the opportunity to be the best integrator and administrator of care as well as have the greatest range and versatility of skills and the greatest flexibility and portability to serve the people.

The Continuity Imperative

In an increasingly technological society, all patients will benefit from continuity of care. It is unfortunate to see disruptions taking place as patients move between office, home, hospital, critical care unit, and nursing home. The ideal is a warm and supportive relationship with the same family physician serving as adviser, advocate, and friend as the patient moves through the labyrinth of medical care.

For example, the elderly are the principal consumers of critical care. There are many types of decision making that affect the critical care of the elderly. There are gatekeeper-type decisions and decisions to treat or not to treat. If, as a society, we are searching for wiser, more humanistic, and more cost-effective decision making in health care, it would be beneficial to have a deeper knowledge of the patient and his circumstance.[3] One might envision improved critical care by having the same family physician involved in the total health care team in specialized units. Whatever the range of technical skills of the patient's family physician, it is vitally important to have that physician's consultative input. The family physician's role within critical care may depend on a number of factors, such as geographic differences, the scope of the physician's training, and other aspects, but in most instances the family physician should have the best understanding of the patient and be in a position to make an important contribution to the patient's care. Communicating the substance of knowledge and understanding of the family physician to other specialists is an important duty that requires specific training for this role. This duty should not be simply a social call expected of the family physician on a sporadic basis.

This role of continuity applies not only to critical care units but also to general hospital, home, and long-term-care facilities.[4] Visitations to the home and to long-term-care facilities are absolutely required in providing excellent patient care to the elderly. Failure on the part of physicians to make visits as necessary in the home and in the long-term-care facility relates to several facters in the United States, including training and physician attitudes. Our educational systems have been remiss in excluding the home and nursing home as proper environments for medical education. Physician attitudes have been a problem, in that physicians have been more interested in the acute aspects of care than in long-term care.

Many of our problems in health care are related to failure in the continuity of care. With an increasingly older population, increasing subspecialization and technology, and the cost implications of care, the greatest attention in the future must be given to the principle of continuity of care by a family physician.

Concern for the Entire Family

In caring for a young parent with cancer, a child with mental retardation, an older person with senility, or an adolescent with psychological problems, the physician is not simply dealing with the individual patient. The physician is dealing with the entire family. For example, in the care of the elderly, every physician should consider those means that would keep an individual at home, either with spouse, with family, or alone. It may be more critical for the patient to remain in a comfortable and familiar environment at his or her own home, despite limited access to therapy, than to reside in a long-term-care facility. The physician caring for the elderly patient should be concerned about means to bolster the family unit.

The operating forces that result in patients going to institutional settings are not always under the control of the medical community in the United States. Although I believe our society has erred in creating nursing home beds out of proportion to alternative forms of noninstitutional care, there are several other forces that make institutional care unavoidable. With increased mobility of families, there simply may not be family members available to participate in the elderly patient's care. Homes are no longer architecturally designed to house an extended family, but rather are based on a small nuclear family. Finally, the increased occurrence of women joining the work force is an important factor in the lack of an available family member to stay home with the impaired or disabled elderly person.

Despite these forces, there are many families in the United States striving to keep an elderly member either in the extended family setting or in the elderly member's own home. It certainly should be our goal as physicians to keep elderly persons functioning independently with self-respect, preserving their life-styles as much as possible. Clearly, we would want to keep the married couple together or an elderly single family member living with his or her children. The physician should use the prescription for a nursing home as specifically as a prescription for digitalis or an antibiotic.

What alternatives can physicians use? A simple list includes day care, home care, specialized housing settings, homemakers, home health aides, visiting home nurses, friendly visitors, foster home care, congregate and home delivered meal programs, transportation programs, and shopping services. Hopefully, we will see the emergence of other forms in the future, such as tax credits for family-oriented care and innovative experiments in housing and transportation.

Family medicine is concerned about the revitalization of the family unit. Strengthening the family is a critical step in solving many societal problems, eg, avoidance of unnecessary institutionalization in the care of the elderly and a reduction in substance abuse in adolescents.

The Role of the Family Physician in Complex, Ethical Decision Making

"First, do no harm." This concept has also been stated as the principle of minimal interference.[4] The principle of minimal interference can be applied not only to drug therapy but to other decisions, including the use of diagnostic tests, surgical intervention, and decision making regarding institutionalization. The principle of minimal interference may result in decisions that are humanistic and cost-effective; for example, it could result in a decision that the patient should remain in his or her own home, despite limited access to therapy, rather than reside in a long-term-care facility, or a decision not to perform a barium enema examination and proctoscopy in the evaluation of anemia when the patient is terminally ill as a result of a glioblastoma.

In the year 2000, we will be faced with more and more choices and decisions of an ethical nature. For example, two experiences in my recent practice illustrate the types of complex and difficult ethical problems that face the physician.

A young couple moved from Maryland to Texas. The young woman gave birth prematurely to twins, each weighing 0.45 kg. One twin died at birth, and the other was treated in the hospital for six months. At eight months, the twin returned to Maryland, weighing 2.7 kg. The baby was blind and had severe cardiac disease, requiring several operative procedures. At each step of this child's care since birth, one could question whether intervention was justified.

A 78-year-old gentleman had a history of resection of an abdominal aneurysm in 1975, multiple myocardial infarctions, and multiple small strokes, causing severe dementia. This year, he was initially seen with pneumonia, causing a worsening of his confused state. Because of periods of sinus arrest, a pacemaker was inserted. This example raises the question whether pacemakers and other sophisticated interventions are warranted in the patient with severe dementia.

Difficult and ambiguous clinical problems such as these will face the family physician with increased frequency. In the family physician's role as integrator and administrator, he or she must utilize compassion, common sense, and an ability to deal with complex, ethical issues. The family physician will be called on to make complex decisions according to the accepted traditions and values of his or her religion, nation, and society or culture. The family physician's training should include an approach to complex, ethical problems.

The Role of the Family Physician in Prevention

The family physician in the future will place a major emphasis on disease prevention and optimal health. By the year 2000, we will certainly know a great deal more, but it is still uncertain whether there will be absolute breakthroughs in such areas as heart disease, cancer, and the aging process itself.

There is enormous evidence that, in our prevention efforts, the greatest attention should be placed on early environmental influences. Although preventive measures are helpful throughout the entire life span, Dubos and others[5,6] have demonstrated that early environmental influences have profound and lasting effects on the subsequent characteristics of the organism. Early influences of nutrition, psychological stimulation, and infection will determine not only the biological characteristics of the young animal, but will also determine adult characteristics. Dubos' work offers the family physician a philosophy of helping the family improve the environmental conditions of the early life of children, including intrauterine life, thus preventing disease and resulting in the optimal growth, development, and even aging of the family's offspring.

Compassion and Humanism in the Daily Practice of Family Medicine

First and foremost are compassion and humanism. In an increasingly technological society, it is imperative that compassion and humanism should not be lost in daily transactions between physicians and patients. As our patients enter the complex world of specialized tests and treatments, we must avoid the consequent dehumanization that occurs when patients simply become subjects for study and treatment.

In all the great religions, various forms of a golden rule are stated. Surpassing our specialized knowledge or new technical skills at the present time or in the year 2000 is the need to express compassion, humanism, warmth, and empathy. It is important that we remember that "the secret of care of the patient is caring for the patient."[7]

William Reichel, MD

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Mrs. **Bentley**. Let me ask you one quick question. Franklin Square does have an HMO setup, doesn't it?

Dr. **Reichel**. Franklin Square is part of a newly formed GPPO, that I believe is five area hospitals and this is something newly forming called preferred health network. I really am not an expert on that matter. It is developing around the metropolitan Baltimore area.

Mrs. **Bentley**. Dr. Martinez, will you give us your comments on the HMO and their value?

STATEMENT OF DR. JOSE MARTINEZ

Dr. **Martinez**. Madam Chairman, members of the committee, I understood my assignment to be to communicate to you our experiences with out-of-pocket expenses for medicare recipients. I would be glad to supplement my written testimony. However, with your permission, I will depart slightly from my written testimony and address the very same concerns that Dr. Reichel has expressed to you.

Our health care system does not suffer so much from indifference and carelessness as much as it suffers from fragmentation and discontinuity. The patient being moved so to speak from module to module. I share Dr. Reichel's feelings that the ideal medical system is one that provides continuity of care, one that provides management of care, and this is how HMO's operate, and this is how HMO's cut costs. We cut costs because we provide continuity of care. It is a byproduct of our continuity of care and not necessarily our primary objective.

We assign the choice of a primary care physician to any member at the time they join HMO. Admittedly the person joins HMO, if that person has an established patient-physician relationship with the physician who is not a member of the provider group HMO, he or she must sever that relationship, but from the moment a person joins an HMO, he or she chooses a primary care physician, who then becomes the manager of care for that person. He coordinates all the special care, in connection with my office, he arranges for the admission at the hospital, and we jointly monitor the quality of care in the hospital, and provide continuity prior to discharge care by providing it when necessary.

The other thing that HMO's can do, and in parentheses let me say, that Dr. Reichel flatters when he says I am an expert on on the subject of Medicare, I am not. Care First HMO, of which I am the medical director, has only a very small percentage of Medicare recipients at the present time, but we have been preparing to offer a risk contract to Medicare recipients and in the process have had to study the Medicare health care delivery system fairly extensively.

There is a report recently released by the Health Care Financing Administration, entitled "Supplemental Health Coverage Among Medicare Beneficiaries." It is an extremely interesting report and the highlights of that report, which addresses not so much the part B Medicare, which is known as supplementary Medicare coverage, but the supplemental Medicare coverage which is purchased outside the Medicaid by Medicare recipients. Eighty percent of all Medicare recipients in 1980, which is the year studied by that report, had to purchase supplemental coverage and of those four out of five Medicare beneficiaries, 67 percent had purchased private commercial insurance, whether for profit or nonprofit, and 13 percent had Medicaid, and of the total group, 2½ percent had double coverage.

During that year we spent $4.7 billion on noninstitutional care for the aged. Medicare covered only 56 percent, and the remaining, the majority, was paid directly by the beneficiary or by their families, 18 percent. Private insurance paid for 15 percent, and Medicaid for 7 percent.

By now we are all familiar with the limitation on the benefits provided by Medicare, and I will not read that. I do want to point out up until recently, the Medicare enrollment in HMO's was fairly limited. It is because under previous programs, Medicare members could join an HMO under an amendment which involved adjustments of the premium paid to the HMO. This is a very inimical way HMO operates and requires the keeping of two sets of accounting books to justify the cost. HMO's operate on absorbing the total risk for a prepaid capitation.

TEFRA 1982 the regulations of which have been completed and published early in 1985, provided a different mechanism, that of a contract for risk where no interactive adjustments are made, where the HMO paid capitation which currently amounts to 94 percent of the actual adjusted cost for the Medicare received in that region, and is expected to go to 93 percent in 1987. Thus, at the outset, providing a savings of between 6 and 7 percent to the Health Care Financing Administration.

For that premium, plus a premium which is charged the member, the HMO must provide all services provided by Medicare, and in addition, take care of all the deductibles, all the preventive care, all the immunizations, the 20-percent pay for physician services. When we think of the fact that Medicare recipients use outpatient services two to three times more frequently than patients under 65 years old and hospital services about six to seven times more frequently than the under 65, one can see that out-of-pocket expenditure, the deductible and the 20-percent copay can be very significant.

There is data available from the interstudy which compares the 12 months ending in June 1984, to the 12 months ending in June 1985. That is, comparing the pre-TEFRA era to the post-TEFRA era, and even though we only were operating with months of TEFRA since the first TEFRA account was given out in April 1985. If we look at the date, we can see that 4-percent of the Medicare enrollees which in June 1985, numbered 886,048, have joined HMO provided Medicare contracts and most have joined either group networks or they have joined group model networks. Suggesting that the feeling we have of people over 65 have difficulty severing the relationship they have with the existing physician may not be a fact.

We also should see that the increase in the number of HMO's in that comparative period was about 24 percent but the increase in the number of HMO's providing Medicare contracts was 71 percent.

I do not want to take more of your time, but I think that HMO's do provide an effective alternative, a cost-effective alternative to the current system.

[The prepared statement of Dr. Martinez follows:]

PREPARED STATEMENT OF DR. JOSE MARTINEZ, DIRECTOR, DEPARTMENT OF MEDICAL AFFAIRS, HEALTH CARE CORPORATION OF THE MID ATLANTIC, BALTIMORE, MD.

In its 1985 report entitled "Supplemental Health Coverage Among Aged Medicare Beneficiaries" H.C.F.A reports that , in 1980, 80% of Medicare recipients found it necessary to carry Supplemental Medical Insurance. This should be differentiated from the Supplementary Medical Insurance , or Part B, of Medicare.

Of those 4 out of 5 Medicare beneficiaries 67% had a form of private or commercial insurance while 13% had Medicaid. 2.5% carried both forms of coverage.

During the period of the study out of pocket expenditures for health care were highest among those carrying Medicare only (29%) with those carrying private supplemental insurance underwrote 20% and those recipients carrying Medicaid in addition to their Medicare coverage were responsible for only 4%.

41.7 billion dollars were expended in 1980 on non-institutionalized care for the aged. Medicare paid 56% of the total cost. Of the remaining 44% the greatest portion (18%) was paid by beneficiaries of their families. Private insurance paid for 15% and Medicaid 7%. Not included in this calculation is the cost of the premiums paid by Medicare beneficiaries for the private insurance supplemental coverage.

Part A of Medicare (the Medicare Hospital Insurance) requires the beneficiary to pay, for the first 60 days of hospital care, a deductible which is estimated by H.C.F.A. to reach $600.00 for the forthcoming year. Since this is not a function of the duration of the hospitalization but rather a reflection of the increased intensity of services due to shortened length of stay, it is an out of pocket expenditure faced by all Medicare recipients admitted for inpatient care

In the event of a hospital stay exceeding 60 days a daily copayment of $ 123.00 comes into play which rises to $ 246.00 a day after the 90th day. Beyond the 160th day all costs are absorbed by the beneficiary.

I hasten to say that the average hospitalization is not long enough to bring such out of pocket expenses into play and that in general a Medicare beneficiary ,though under risk of these payments, is not faced with such additional expenditures.

While part B of Medicare provides for physician and ancillary services it is often forgotten that it does not pay for routine preventive medicine services with their attendant laboratory tests and X-rays. Neither does it cover immunizations. This limitation of coverage may well add between $ 100.00 and $ 250.00 to the annual out of pocket expenditures, assuming that the services have an annual frequency.

For those physician and ancillary services related to acute or chronic illness Part B requires an annual deductible of $ 75.00 and will pay for only 80% of the reasonnable charges. These out of pocket expenditures are significant when the provider accepts assignement and even more so when he or she does not.

All these out of pocket expenditures are magnified by the fact that the aged population utilizes out patiewnt and office services at a rate of about 2.5 to 3 times that of the under 65 population and that the services needed tend to be more cost intensive.

Finally Medicare does not provide for prescription drugs. Illnesses of the aged tend to be chronic and tend to require continuous treatment with medications.

We have seen in the H.C.F.A. report that the greatest weight of the out of pocket expenditures for health care falls on beneficiaries and their families. It is clear that deductible and co-payments which were initiated as a reasonnable deterant against inappropriate use of health care resources are rapidly becoming a barrier to accessing necessary care.

H.M.Os have always played a role in providing care for the aged. Prior to 1982 coverage was mostly provided through "wrap around" or "Medigap" programs and mostly through conversion of existing memberships at age 65. Capitation programs were also available with retroactive adjustments by H.C.F.A. to reflect the actual cost incurred by the H.M.O.

Such programs were incompatible with the HMO managed care approach which provides health care through non adjusted prospective capitated payments. Thus HMOs did not actively promote Medicare membership.

In 1982 TEFRA (the Tax Equity and Fiscak Responsibility Act) created incentives for HMOs to increase their Medicare enrollment by removing retroactive adjustments.

Capitated payments to HMOs are now calculated on the basis of 95% of the applicable Adjusted Average per Capita Cost (AAPCC).The HMO however is fully at risk and may not recover losses by changing its premium structure should it fail to prudently manage it health care budget. Thus TEFRA can be said to have brought "risk" to HMO risk contracts.

Under such a contract the HMO receives a capitated payment from H.C.F.A. and may charge the member a monthly premium.

In exchange the HMO must provide all of the Medicare benefits, absorb all deductible and provide a supplemental health care package which included all routine and preventive care, all office and outpatient hospital care, all laboratory and X-ray services, all immunizations and may provide additional benefits. Most HMOs elect to provide prescription drugs.

HMOs may require a small co-payment for certain services but the aggregate of such payment in a contract period may not exceed the aggregate premium paid.

The comprehensive package and the premium are reviewed and approved by H.C.F.A.

The final TEFRA regulations concerning the operation of HMO "risk contracts" for Medicare beneficiaries were published in early 1985 and the first contract was signed in April of 1985.

Data are available which compare the twelve months ending June 1984 (pre TEFRA) to those ending June 1985 (post TEFRA).In spite of the very short period of activity under TEFRA interesting trends and significant changes can be seen.

In the 12 months following June 1984 the total number of HMOs increased by 29% while the number of HMOs with Medicare contracts rose by 71%. Medicare enrollees increased by 38% while total HMO membership increased by 25%.

41% of Medicare enrollees have joined group model HMOs and 30% have joined network model HMOs thus suggesting that the Medicare population may not be as opposed to some limitation of choice of provider as one would have believed.

There were, as of June 1985 a total of 886,348 Medicare enrollees in HMOs with the greatest majority of the enrollees belonging to comprehensive plans (76.4%) and the minority (23.6%) receiving only supplemental benefits through a "wrap around" program.

HMOs provide an attractive alternative for comprehensive health care coverage for the aged under an HMO risk contract.

The main obstacle to the successful integration of Medicare beneficiaries in a managed care program may be in the established pattern of care and the established patient-physician relationship which the Medicare beneficiary may be loathe to relinquish as well as the difficulty inherent in adaptation to the requirements of a managed system of health care.

The latter can be ,and is, addressed by membership information and education.

The former can only, and should only, be addressed by the excellence and the quality of the care provided coupled with decreased out of pocket costs to the beneficiary.

Mrs. **Bentley**. Thank you.

Dr. Pierpont.

STATEMENT OF DR. ROSS PIERPONT

Dr. **Pierpont**. To identify myself a little more closely, I have been a part of this medical scene since 1945, and active practice——

Mrs. **Bentley**. I didn't want to give your age away.

Dr. **Pierpont**. I understand that when you are talking about the aging you are talking about me. So I have a more than vested interest in it, and I want to just say that I started Blue Shield, we started that in this State in 1947. I was an original participant and they took 25 percent of our original fees to start that program and the fees were very poor, I might add, we got $50 for an appendectomy and contributed $12 and a half back. But that is just an aside to give you an idea where we come from here.

Let me first compliment Helen Bentley, an old friend of mine, for a heck of a job as Congresswoman of the Second Congressional District, and no one could have done a more excellent job for the Port of Baltimore for stimulus of jobs for the district and for her organization and dedication to service to each individual.

Mrs. **Bentley**. Thank you.

Dr. **Pierpont**. That is a paid political announcement.

But in all seriousness now, if you can solve the health care problems, Houdini will live again.

The medical care problems of the elderly with Medicare and Medicaid do not differ very much from those of the general public. The problems are accessibility and how the cost of care will be covered.

The problem has occurred because of the third-party payers who offered coverage for health care—government, labor, industry, insurances such as Blue Cross and Blue Shield, Travelers, individual HMO's, PPO's, et cetera—have overpromised expensive expanding

Medical care and now cannot pay the bill to fulfill their contracted obligations.

Massive expensive bureaucracies have been created in government and the private sectors. These bureaucrats and the expensive lawyers and legal systems used to support them are using huge slices of the health care dollar in regulations rather than care. Much of this should be eliminated.

HMO's, PPO's, IPA's, et cetera are all attempts to cut cost. That is why they were created. All expect to make money for their organization by rendering treatment for your health care dollar. All expect to furnish more Medical care for less money by regulating access to care with primary physician gatekeepers to block entry and frequently to do less for you, the patient, than has been promised. At the other end, the cost of service is cut by using a closed panel group of physicians who agree to a lower fee. For the most part, the cost of HMO enrollment fees is higher than other health plans.

You must understand, instead of patients, you are viewed today as market share. Blue Cross and Blue Shield advertise on radio and television their HMO "Columbia Medical Plan—anything else is a compromise." On the same program another ad: "Free State—we are cost busters, enrollment has doubled in the last year." Which of these or are both a lie, and a fraud? Select Care, the PPO of Blue Cross and Blue Shield, started 1 year ago using only low-cost hospitals and cutting physician participant fees 20 percent. Complete control of costs—what happened on renewal date April 1, 1986? The fees were substantially increased.

I belong to everything they have got. When you get to be a secondary provider you get to be sort of like an occupant of a bawdyhouse, you get that same service no matter what you pay. So, whether the patient pays nothing, we do the same operation on him, whether he pays $1 million we do the same operation. It doesn't matter.

So what we are speaking of here is this select care came out, and they cut their fees 20 percent, and they chose only low-cost hospitals and did all these things and fine, this is going to cut the cost of Medicare and they are going to be able to control it.

I run a small place. We had 17 employees. We have been on the rolls ever since they started in 1947. OK, we will do it again, we went in. Select Care. What happened to April 1? The fees went up. Now, if you can't control what you have got absolute control of, tell me about the cost. Just bringing out one situation.

There is no free lunch. As the above examples illustrate. Evidence is accumulating that the excessive regulation is costing more than it is saving and at a real cost and risk to the personal health and comfort of the patient.

It is important to retain your choice of physician, care, your ability to pay and the guarantee of good quality care.

This must be a cooperative effort in the American way. Patient self-responsibility with some copay plans, voucher systems, and understandable fee schedules. Government and private insurers must have a control on costs with some form of capitation system.

But allow me to close by drawing on a personal experience of observing several medical systems. In European nations where health care and social engineering functions, a good 15 percent of gross national product is dedicated to this purpose. In the United States we fall short of this goal by about 50 percent at 10 percent. In the final analysis it is up to all of us as U.S. citizens to set our priorities and match our desires with dollars. Then we must run a tight ship. It is our money and our health.

[Supplemental material submitted by Dr. Pierpont follows:]

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June 22, 1982

Editor
Morning Sun
Calvert and Centre
Baltimore MD 21203

Dear Sir:

The report in The Sun of June 21, 1982 of the ten companies doing preadmission reviews on their insured personnel is most interesting. This is especially true since it follows so closely the unanimous rejection of a resolution presented by the Baltimore City Medical Society to endorse a consortium of physicians to operate such a review.

The public is entitled to know why physicians would reject this idea when they are as interested in holding down costs as anyone else. For consideration, the proposal of the ten companies listed in your paper may be used as an example. We can assume that each of the ten companies has as a priority item their bottom line profit figure. All are interested in the good health and care of their employees for good work schedules and production. Nearly all are involved with a health package as part of union or other negotiations. Nearly all decry expensive cumbersome bureaucracy and have embraced the cutting back of regulations and red tape by the government under President Reagan. What then is to be done about the increased cost of health care to these companies?

These companies should do what is necessary when confronted with any fiscal problem. Cut the cost at its source. Some suggestions.

1. Don't negotiate health benefits you cannot fund.
2. Don't supply unlimited open end services.
3. Don't obligate more money to health services than the company can afford.
4. Don't, above all, form your own private bureaucracy. It will be no better than the public one you have replaced. P.S.R.O., a regulatory agency for hospital utilization, was one of the Federal bureaucracies to feel the axe. The wails of anguish of the affected bureaucrats have only been exceeded by the noise of scrambling to replace the public bureaucracy with private bureaucracy.
5. Don't confuse the issue by off loading the problems you have created on the backs of physicians who had no part in your health bargaining.
6. Don't ask the physician to involve himself in the hassle to shoe horn a displeased patient into an over-promised insurance plan that you can't fund.
7. Finally, an old and true axiom, if you can't afford it, don't do it.

A final word is in order to correct a misconception about Medicaid savings listed in your article. This is no mystery. If the money is cut off--as it was by the Federal and State government--and you make it difficult enough for the poor to be served (they are the Medicaid recipients) it is easy to save money. In a nutshell, this is what was done. They hired a few more bureaucrats to do it. In essence you will save just as much as you decide not to spend.

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RZP:ms

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PRESENT HOSPITAL AND MEDICAL DILEMMA

What is most remarkable and anachronistic about the present dilemma with high health care costs and excess hospital beds (which incidentally are one of the prime cause and effect mechanisms in the problem), is the fact that the same forces and individuals who caused the problem are now attempting to cure it.

The Federal Government, the insurers, business, labor and the hospitals produced the high health care costs. The Federal Government legislated fiscally unsound programs in Medicare and Medicaid which were overpromised to an eager insatiable public. From day one, the government's Federal, state and local, were unable to pay the promised amounts of money to providers - e.g., hospitals, nursing homes, physicians, etc. It took a little longer with Medicare but the obvious difficulties were evident early. Unfortunately, no legislator depending on this largesse for votes was about to deal with the necessary fiscal responsibility. Finally, with the programs facing imminent bankruptcy, something has to be done.

The insurance companies had no incentive to save money. Quite the reverse. The higher the pay out, the higher the premium and, even with the same percentage, the greater the profit. There was every reason to increase fees and hospital charges - not decrease them.

Big business, when faced with problems in their labor negotiations, frequently offered sweeteners of health care coverage. Many times this was expediency of the moment to get signed labor agreements, but the problem has come back to haunt business as costs, which had been glossed over in the desire to sign a contract, escalated.

Labor leaders have a job to do for their members. First on the list is satisfaction of the membership or the leaders are not re-elected and lose their jobs for not getting more. Health care packages with eyeglasses, dental care, preventive medicine etc., were negotiated and business was a willing participant in contracts which were too costly to begin with and since the service was free, it was overused and abused.

Hospitals must have known or should have known of better ways of delivering health care at lower rates. Mayo Clinic has done this since 1922 with hospitals used only for acute care and juxtaposed residential facilities, e.g., hotels, homes, etc., used while diagnosis, pre-operative care and recovery is being conducted. Associated with these facilities, Mayo Clinic has diagnostic and out-patient treatment facilities which are much less costly and more efficient than in-patient hospital activity.

The solutions are obvious. Why can't we get at the problem and cure it?

All of the listed groups - Federal, state and local government, insurers, business, labor and the hospitals - have amassed huge bureaucracies over the years. Bureaucracies contain bureaucrats who are people just like you and me. They are human beings who have jobs to protect. Since self preservation is the first law of man, how can we expect these groups to dismantle themselves even in the good cause of better care for less cost.

It is in this arena that the Federal Government has the greatest responsibility. The Federal Government holds the key with the purse strings. Only by closing the vault can you produce a satisfactory result. The present activity of producing more bureaucracies with more and more regulations, e.g., P.R.O., quality control monitors, H.S.C.R.C., etc., is not the answer.

We should judicially cut off any money we cannot afford to spend, and let the citizens of this country inside and outside the Health Care System work out the problems. In a word, let the free market place operate. Have the government unravel regulations and bureaucracies and wind up with a more efficient, less costly, and better Health Care product which will be more satisfactory and gain a high degree of acceptance from the public.

Ross Z. Pierpont M.D.

Mrs. Bentley. I want to thank our three eminent physicians for their statements, and Dr. Reichel, you mentioned the year 2000 several times. Someone in recent weeks—you may have been the person who told me this—it is predicted that by the year 2000 we will have over 1 million people who will be 100 years or older. Did you mention that to me?

Dr. Reichel. In my papers, which are enclosed, in the testimony, I refer to the rising number of older people and with more and more older people, and more and more high technology, it is important to have somebody in charge of the patient and looking at the whole thing so that people don't just on their own select a pacemaker doctor, that there is somebody at the helm.

But my concerns about the personal bond developing between doctor and patient and continuity of care weren't entirely clear. I was suggesting those points of criticism of HMO's. It is a danger if HMO's do not fulfill that. I think the best personal bond is between the family doctor and the patient and the best continuity is between the family doctors and patients. How much an HMO absorbs that into their model is how I think we should measure them. I know that there are HMO's where people can walk in and maybe be seen by a different person or by a physician's assistant or nurse-practitioner. I was really offering those comments as a way of measuring HMO's and PPO's that are developing.

The other problem with the HMO's is with the care of the elderly. They, by and large, have aimed for more of the younger people. I believe now there is more and more interest in HMO's developing in Florida and now some of the demonstration projects are being more involved in the care of the elderly. Since care of the elderly is so expensive, it is advantageous for many HMO's to avoid care of the elderly. What I hope is that this is going to change, but my comments were mainly as a criticism of HMO's.

Mrs. Bentley. OK.

This question does not concern HMO's per se, but have you as a physician, found that the Government, and the insurance company's limitations, of the DRG limitations on hospitals, on time, does not take age into consideration? In other words, they may give 5 days for a heart situation, whether the person is 25 years old or whether he or she is 75 years old. Is that true?

Dr. Reichel. I am not certain how much it is taking.

Mrs. Bentley. I was using that as an example.

Dr. Reichel. This whole DRG type of thing and whole utilization type thing is a harmful aspect, an aspect that raises major ethical questions about—that, for example certain cataract surgery must be done as an outpatient and this can be very hard on the older person, to get ready in the morning, when they have to get up at 4 in the morning to get someplace in time. My own mother had to have a procedure at 8 in the morning, and not only are there transportation problems that elderly have in general, but to aim for 8 in the morning to have a procedure and they are pretty shaky in the morning.

There are a lot of aspects of the entire DRG sort of thing, and utilization type review that we all really must question. I think all of us are seeing incidents in the elderly and all ages that we have to worry about. For example, does a certain plan call that the person must go to one facility, one doctor. There are these aspects I think in every city now. There are incidents where people are actually being hurt or suffering morbidity and mortality because of that. There are such incidents being reported in the literature.

Dr. **Pierpont.** There is a way around this. Not far from you out there is the Mayo Clinic, which did it in 1922. Unfortunately, we have been unable to convince the regulatories, because, you see, everybody got into the hospital business and built all the hospitals all over the country. Instead of building hospitals, we want to do demonstration projects with Maryland General going out to Hunt Valley. We wanted to put up a small hospital, a few acute hospital beds. Today you need hotel rooms, but you won't even let us in the State of Maryland build them. And it is not just the State of Maryland, it is through the Joint Commission of Accreditations through the whole gamut of regulatory bodies.

The Federal Government is just as bad. They are all just terrible on this. We can't move it backward, take any one of you in the hospital today, and do a hernia on you and just let you stay overnight in the hotel room. That is all you need. We can get a nurse to go by and make sure you are all right. That is a lot better than going home, which we have to do today.

He asked me a question. We do have people 85, 86 years old, fixing hernias, go home the same day and can't manage, can't do this and can't do that. We have overcome that by establishing rooms until 10 o'clock. There are lots of ways to do it.

It was all dead wrong. You have heard me talk about this since 1960. I have been fussing about this ever since I stayed at the Mayo Clinic as a patient and also as a visitor. I have said over and over it is so patently obvious. Why don't we do it? Nobody wanted to do it because everybody was making money. They made a fortune. This was a good welfare system not only for doctors, for hospitals, for insurance companies, a great welfare system, so nobody wanted to break the back of it. We had a heck of a time suggesting it when we are trying to break the back. We have a whole group of regulators that are making money regulating. We need you all to break it loose. In all fairness and honesty, this is the place you can really break it loose for us. You break down the regulators so we can move, and we can do a lot better job and could have done a lot better job with a lot less money. Nobody wanted to hear that either because they had a lot of bureaucrats and regulators they had to give jobs to, that is why.

Mrs. **Bentley.** Mr. Tauke.

Mr. **Tauke.** Dr. Pierpont, I know you have great admiration for your Representative in Congress, as we all do. Could you find another district where you might run, because I think maybe we need some——

Dr. **Pierpont.** I have.

Mr. **Tauke.** Let's try it again.

Let me say a word about, or ask a couple of questions about this point you just made relating to both the hospitals and regulators. First of all, on the hospital side, I think Jim indicated earlier, that patients are going in sicker and they are coming out sicker. But of course in a real sense that has been part of the goal of the DRG system, to make hospitals actually acute care centers rather than centers for providing other than acute care. Is that an unfortunate or incorrect goal of the DRG system, or is this something that is appropriate to do? The problem is that we haven't spoken to the other levels of care which should be available to that patient who needs acute care.

Dr. PIERPONT. More of the latter than anything else. In that we should convert most of our hospitals to half hotels but we can't. You see, that is what we ought to develop and it is easily done. We have two or three levels of bureaucracy in this State that you have to go through. It takes 8 to 10 months to go through this business of regulator boards, instead of just coming out and proving that the bottom line is less and the care is better.

Mr. TAUKE. Dr. Reichel.

Dr. REICHEL. Yes, sir. The problem is that we are spending too much money, but with more and more older people, by the year 2000, and more people living longer, we are all going to be part of that, with more opportunities for helping people, with more people requiring long-term care either in a nursing home or with home care, or day care, it may just be wrong to say that we can lower the amount that we are spending.

The health care industry is such an important industry. It means jobs for people and is such an important part of the economy. The entire premise is that by year 2000, as we keep adding more older people, keep adding things we can do for people to improve the quality of life. The entire problem is we do need to get rid of waste and fraud and some of these very negative things, but we might even think of the fact that maybe we should be doing more for people and actually spending more.

Mr. TAUKE. I don't start from the premise that we are necessarily spending too much, but I will say that I think as long as the Federal Government is the primary payor of health care services, that decisions about health care are going to be budget driven. I think that that is a reality of life upon which we must agree as a starting point for making judgments.

Now, over the last several years, there is no question but that as the cost of health care has moved upward, and the Federal Government has been faced with the budget squeeze, that we have attempted to squeeze down the system. Now, how do you go about squeezing down the system? We certainly wouldn't say as policymakers that we can't deliver all the promises that we have made to people because we continue to want to be able to say that we will promise everybody the best quality of health care available if they need it. So we wouldn't want to say that we are going to back down in our promises. So instead, what we do is establish a regulatory network to squeeze down on the system.

Now, obviously there was some fat in the system—at least I think it was obvious—and some of that is being squeezed out, but I suspect that squeezing it out via regulation is a very inefficient way of doing it, and also is a very, in my judgment, arbitrary way of doing it, and I suspect is a way that is patently unfair, because it doesn't treat all areas of the country or all individuals the same.

I suppose that part of my concern is that as health care policymakers we have attempted to put the Federal Government in the position of deciding who gets care and when they get it, and now we are trying to ration that. Since we don't want to ration that, so we are forcing providers of health care to ration the care.

We do it all for budgetary considerations, I guess, which leads me to believe you have to change fundamentally the way in which we drive the services and I don't know exactly what that means, but I do think that perhaps we ought to be looking at things like saying to individuals here is the money, you go out and purchase your health care services and I think we would see much more rapid change, which would allow for the levels of care in the system that are so obviously needed, where as now, as has been discussed in this panel already, hospitals are unable to adjust in order to react to the realities of the times.

Dr. **Reichel.** I am glad you are open to the necessity that we mustn't cap it down and squeeze it down. Maybe it should be expanded.

Mr. **Tauke.** I think I should—I am not sure expanding it under the current system is reasonable considering the other realities within which we work.

Dr. **Martinez.** I have only been medical director for 2 years, until then I had private practice. A doctor in the field of nuclear medicine asked me what the difference between what you used to do and what you do now, and I told him very simply, I used to take care of trees, now I take care of the forest.

You must get the overview if you want to satisfy the need of the individual, because the challenge that faces us is a redistribution of resources, and a rethinking the initiatives by which we provide those resources to our patients.

Of course it is terribly traumatic for an 85-year-old to be awakened at 4 a.m. so they can be in the operating room at 8 a.m., but maybe the answer is to operate in the afternoon, not in the morning. We have to rethink how we are going to spend the money and the mechanism by which we provide the services.

Is it really necessary for a perfectly healthy person to spend the night before a simple surgery in the hospital to be evaluated by the anesthesiologist, couldn't that evaluation be done as an outpatient 48 hours before surgery or the evening before surgery? So, we as professionals I think have the obligation to rethink how we are going to keep our contract with society, given the budgetary constraints we all must live with.

I am a believer, a firm believer, in competition, but I think the role of the government is to provide the limits of the ring in which the competition will take place and the information we need to make informed decisions.

Mr. **Tauke.** I think you make a good point. I think I can concur with what you are saying. Our problem at the moment, it seems to me—this is an oversimplification—that we are getting to the point where the Federal Government will make the decisions whether the surgery will be in the morning or the afternoon, and I don't think we are the ones who ought to be doing that. Somehow we ought to in a sense do those things, make those judgments, then provide the resources to make certain that people have access to decent health care.

I might just mention, we haven't even talked about the 35 million people floating around the country who have no coverage, most of those are not in the elderly component, that is another major problem.

Without getting on my soap box, let me ask one other question, which I think is important. We have had a lot of discussion over the last couple of years about the professional review organizations—the PRO's—and every time we have discussions about the quality of care that is being delivered to elderly citizens and others, the answer always comes back, we have the PRO's out there assuring that there is a quality of care delivered to individuals.

My own observation has been that the PRO's may be more interested in holding down the costs than they are of assuring quality. I just want to know if you have had any experience with them, if you have any observations about the way the PRO's are operating, the system is operating?

Dr. **Pierpont**. Well, the PRO's, you basically have the proposition correct. The PRO's first are another bureau which has to compete for its survival with a protocol and a budget and based on that budget and based on their ability to stay within the budget and rationing it down means whether or not they are going to survive or not. So the quality of care, if it is not their last priority, it is their next to last.

Everybody gives lipservice to quality of care, but the guy wholly interested in quality of care is the patient and his doctor, and that is about it. The rest of them really have got to watch that bottom line. You put the pressure on them to the point where they have no choice. You hit the nail on the head, that is where they are, and it isn't that they are against it, it is just that it gets in the way sometimes of getting a new contract nailed down, and if that gets in the way, you make a guess as to what is going to happen. Is the quality going up or down, or the price going up or down?

Dr. **Reichel**. I think the feelings of many physicians in Maryland is the PRO was very draconian in rules as to what can be operated on in the hospital, what has to be done as an outpatient, and again, presenting a great deal of hardship for patients who have all sorts of types of surgery, for example. Has that not been the experience?

Dr. **Pierpont**. Yes sir. It comes back to the same thing I just said to you. If you said to all of us, cut your beds in half tomorrow, but you can have hospital beds, hotel rooms, by golly we could do it. There would be a lot of grunting and groaning because an awful lot of people have nose nip. You would have to take the brunt from the JCAH and all the rest of them every time you put a patient in the hospital they have to have certain things—so many nurses, so many orderlies, so much of this, huge costs. They would all be eliminated if you move out of the way of all that bureaucratic fandangoing.

So there is where you really can help us. You can really help us by doing that. If you get them out of the way, we can deliver to you.

Dr. **Martinez**. My department is a PRO, the Department of Medical Affairs Care is charged with both reviewing and equality assurances. I think you have to be a very, very constrictive schizophrenic to do a good job. I think you have to really separate the two functions, and I think that PRO's should not be regulators.

They should be in the character of information gatherers and educators.

I will agree with both Dr. Pierpont and Dr. Reichel, the physician and patient are the ones most interested in quality of care, but I will add I, too, am interested in quality of care, because of the responsibilities I have accepted on behalf of the members of my organization.

Mr. **Tauke**. Thank you.

Mrs. **Bentley**. Mr. Lightfoot.

Mr. **Lightfoot**. Thank you, Mr. Chairman.

Dr. Pierpont, back on this idea of the hotel room, how much of that is State regulation and how much of that is Federal? I am aware of some of that going on in our State.

Dr. **Pierpont**. It is both, and also in the medical profession, we have the problem all across the board, but principally, of course, this Federal creation mandates the State and the State operates. So, I don't know. I don't know whether it is the chicken or the egg. I can't reach out and catch what one it is. It is the State talking to us; they are your representative; and they won't let us do these things that we want to do.

Now, we surreptitiously do some of them but it is not correct, so we have to hide those as best we can. So we do need from you the authority to do it. The University of Iowa does this. I finished there as a matter of fact, in 1945, and they do this. They bring people in with the branches of service, have the outpatient activity, and only deliver to the hospital for the acute care. Then back out to the home. But they are taken care of right there in Iowa City and then sent back out to Des Moines or Fox City or whatever. You are familiar to a degree with this type of format. It is on a different basis than the Mayo Clinic, where you have to deliver yourself.

Mr. **Lightfoot**. Thank you. We have some hospitals that have gotten into this due to the reaction of their census going down because of DRG. They had an empty wing and decided to provide, as you say, a hotel service, which is working quite well.

Dr. **Pierpont**. Many of the small hospitals are just waiting to close, except for acute ambulatory services. I just talked to some fellow out in the Northwestern section, and he told me he thought his place would close because of the problem of not being able to keep people. See, you gave us an awful bonanza when you let us stick people in the hospital. Blue Shield continued it by paying for 30 days. So, people just kept them and they just sat there, and I don't blame the patients, they encouraged them to.

Now we have changed all the rules. That is all right. I never was for what we were doing in the first place, so I had no trouble changing the rules. I do have a great deal of trouble with changing the rules and then binding us into problems which are impossible to manage.

Mr. **Lightfoot**. This is a bit of a side bar. Dr. Reichel, you mentioned the rebirth of family practice, which—I come from a rural area where the family physician is the stalwart of health care in our part of the country. Yet, we are starting to see something now that appears, to me at least, is going to be a very large detriment to that, through the malpractice suits and so on that are going on.

In a little community 24 miles from us, the doctor gave up obstetrics last year. He figured out it cost $400 per delivery for his malpractice insurance. Now if a woman is going to have a baby, she has to go nearly 70 miles to find a doctor. Is that going to be a real anchor around the neck of the rebirth of family doctors, because they are exposing them——

Dr. REICHEL. It will probably put out the obstetrical role of the family doctor. In fact, not only for the family doctor but for maybe 16 to 25 percent of the obstetricians will actually give it up, tragically. So it certainly will affect the old family doctor. But actually, the family doctor is better off with malpractice, because there is so much trust and a bond—if there is that trust and bond that I was talking about, that actually tends to lower the whole malpractice crisis. That way the family doctor is better off, but the family doctor will have to give up obstetrics and maybe minor surgery that he might have done in rural areas. It will affect the family practice that way.

Mr. LIGHTFOOT. We haven't at this point seen that kind of impact on services that you gentlemen deliver to our senior citizens, but it would——

Dr. REICHEL. It is causing us to overorder tests, especially overorder. For example, you want to make sure that if somebody bangs their head and you might not have ordered a skull x ray, you will order a skull x ray or cat scan. It really is affecting our care across the board and it has some very negative effects. We have gone through quite a crisis this past year in Maryland, especially in obstetrics where it has gone up to $40,000 a year for obstetricians and I believe 16 percent of the obstetricians have dropped out and it may go as high as 25 percent dropping out of the OB part but retaining the GYN part. It really is a crisis even affecting the care of the elderly.

Mr. LIGHTFOOT. If we don't reform the tort system, and get some limits on punitive damage payments and this type of thing, what do you see as the impact on senior citizens in terms of care that you will be able to deliver. Is it going to be cut back?

Dr. REICHEL. I don't see it specifically affecting elderly. I see it affecting society in general, but particularly fields like obstetrics and other high risk fields like neurosurgery or pediatrics. Those will be the ones hit the hardest.

Mr. LIGHTFOOT. One final question—two quick questions.

Dr. PIERPONT. Let me say something there. I think there was an article in the paper this morning relative to the study commissioned by President Reagan relative to the whole tort system which really needs redoing entirely. We are under seige. Not just us, but the entire United States is under seige by the legal system. The whole system needs to be changed, jury system, the whole business. It has got to be gone through with a fine tooth comb and changed, because if we don't, we are just dead. Take myself, for example, I am 68 now. One of these days if I want to slow down, I can't afford to, because my malpractice insurance is over $2,000 a month, and I don't steal from people. It takes me a while to earn that and consequently, I have got to the position where I have to look very carefully in determining should I quit? I am all right so far, at least I think. Some of these guys may tell me different, but I am all right so far. I have lost one neurosurgeon, I am in danger of losing my other at Maryland General. I have been chief there since 1960.

They are just quitting because their malpractice insurance is so high they cannot continue on in this arena. That is utterly ridiculous to knock out our best sources of help in the United States just to run a welfare system for a bunch of lawyers. It is ridiculous, that is really what it is about. Trial attorneys, they say they are not in majority of the legislature, but they are on all the committees. They do control. They are controlling factor in there every time I get with them.

I can tell you the legal system has us all under seige. It is not just elderly. It is not just us. You, too, are paying through the nose for the products. We are overpaying for everything.

Mr. **Lightfoot**. I guess one of my worse travesties we ever imposed on the American people was withholding of income tax because people were aware what they paid in taxes. Each week we have a lot of changes made. Maybe as a way of education, when you send your bills out you ought to show what portion of the fee is going for malpractice.

Dr. **Pierpont**. We have thought of that.

Mr. **Lightfoot**. I think a lot of people aren't aware of this.

One final question which I would like all three of you to comment on it. There has been talk of catastrophic health care, there is a Presidential commission taking a look at that. At this point in time do you think we should go that way and if so, any observations?

Dr. **Pierpont**. I will speak loudly at once, it is absolutely essential. One of the most important factors, we should not allow people to become impoverished because they need health care.

Dr. **Reichel**. I agree. We need it, we simply need it.

Dr. **Martinez**. I concur with my two colleagues.

Mr. **Lightfoot**. How should we pay for it, should it be private pay through an insurance company?

Dr. **Pierpont**. Yes; I told you about the Germans, they pay another 5 percent of gross national product. It won't cost anywhere near that, but it is not all that expensive. Catastrophic health care figures ought to be not all that expensive and I think we ought to set up a floor under people. I don't think they ought to be down on the bottom asking for Medicaid before aid gets to them. I think we ought to have some number at which catastrophic health care takes over, and we look after people. That is a thing I think we ought to develop. There are so many things. We established sometime ago a nephrology program.

If you think you have a problem, I came along at the beginning of all these things. In nephrology in many countries in the world, they simply do not dialyze an individual over the age of 50 or 55, they select some numbers. I couldn't get dialyzed until I paid for it myself in Germany.

So that is what we are doing. We are dialyzing people because they have got dialysis units, because they have paid for it and it is costing billions of dollars to people here going to survive for a very short period of time, and not being very good to themselves and communities, and they are going to go and they are going to die.

Dr. Reichel. I want to say again I think we shouldn't squeeze things, cap things. We can afford these things, we should be paying for these. How to do it, I don't know the answers on that, but I think we can afford these things.

Dr. Martinez. I am far from being a financial wizard. I recognize the need, I regret that I can't contribute to the solution.

Mr. Lightfoot. Thank you, all three of you gentlemen. I suspect you would like to have us unfreeze your fees as well at this point.

Dr. Pierpont. I don't care what you do with the fees. I have always been for a fixed fee in this country. Whatever the Government is in the business they should have paid all of us the same thing exempt from variation around the country and the cost of doing business. As far as I am concerned I have been for that from the word go. I have told you before it isn't a question of what you pay, it is that you get the same service.

The point is that the fees are not the big issue. They may be with some people, certainly they are not with me, I have never really worried about the fee. One thing with HMO's, which I do think is terrible, is they block the payment from getting to me.

I happen to be a member of a lot of HMO's. I get referred to Care First, as I told you before, the bawdyhouse doesn't select very much.

Mrs. Bentley. Mr. Blaz.

Mr. Blaz. I don't know how to run a bawdyhouse, but I have heard the HMO's mentioned. You have to understand the many members are parts of management of his own care and must contribute to his own care. HMO's are not an answer for everyone. If he is the sort of person that always sees your doctor Friday at 5 without an appointment, you don't belong in HMO.

I do not believe you will ever have a single system of care. I hope we never do. The strength of our society is plurality and I think this is one of the things HMO provides plurality and competition.

Thank you. I am really enjoying this very, very much, but we are a little bit behind schedule so I am going to yield back my time to the chair.

Mrs. Bentley. Thank you, Mr. Blaz.

I am going to ask you one or two other questions about HMO's.

Dr. Martinez, as you said, you have a private practice and you do the HMO as well. What is the cost to belong to an HMO for, let's say, a couple who is 65 or older?

Dr. Martinez. Madam Chairman, I will confess that this falls under another department. I am involved in utilization review and quality assurance. I will answer, however, in broad terms. It is equal to the premium for indemnity insurance and sometimes a little higher. However, you have to look at the fact not only does HMO provide the same benefits as an indemnity program, it also provides for all the routine and office care, which ordinarily is not covered by an indemnity program, so one could say that sure, you may pay as much or a bit more, but you get more bang for your buck.

Mrs. Bentley. Would you obtain the exact dollar amount for the record and submit it to us later?

Dr. **Martinez**. If I may impose on the chair, Mr. Jim Turnock of Care First is in the audience and can give you those figures right now.

Mr. **Turnock**. It would be $41 per member per month. That would be for a couple, $82 per month.

In addition to the contribution to the part B service, which I pay directly to the Health Care Finance Administration, which is $15.20 a month, most people that have that part B coverage through the Federal Government but supplemental coverage would be $41 per month per each individual who decides to join.

Mrs. **Bentley**. So that is $96 a month for a couple?

Mr. **Turnock**. In addition to the $15.20 they pay to the Government. That is not paid to the HMO. That would be paid directly to the Government.

Mrs. **Bentley**. Would you give your name again for the record?

Mr. **Turnock**. My name is James Turnock. I am director of planning and development with Care First.

Mrs. **Bentley**. How does that cost compare, Dr. Martinez, to—I am putting you on the spot perhaps on this—but let's say do you have some of your older citizens who use you in private practice rather than through HMO?

Dr. **Martinez**. I am what you call a tertiary care physician. I provide diagnostic services, nuclear medicine hospital based. Patients are referred to me usually by the primary Care First or by a specialist called by the primary Care First physician.

I can, however, answer your question by comparing the cost of the premium we would require under a risk contract for Medicare and enrollees to the cost of the premium that is required today by indemnity insurance for wraparound contracts—what is called the MediGap contract—and if my memory serves me right, we come to about half of the cost of the premium for a MediGap contract and provide the routine care, the preventive care, and propose to provide prescriptions with a small copayment.

Mrs. **Bentley**. Now, a statement was made that the HMO's don't handle any free patients and that other doctors do. Is that a fact, the HMO's do not treat anybody who does not have a contract with them?

Dr. **Martinez**. That is true. So does Blue Cross-Blue Shield, Travelers, or all the insurance programs. It is a service you purchase. The myth that is frequently perpetrated about the HMO's is that we skim off the healthy population. I will refer only to two things:

The Kaiser Permanente Foundation report issued last year, which demonstrated that actually the yuppy community prefers those programs where they get their premium rebate at the end of the year for not using them. We don't choose our membership. By statute, both Federal and State, we must have once a year an open enrollment. People choose us, we don't choose them. So that there is no skimming off of the healthy population.

Dr. **Pierpont**. Only the skimming of the paying population.

Dr. **Martinez**. May I answer that? There is no insurance program that provides care to the indigent. It does not exist. The only one is the Medicaid Program. Travelers does not provide charity care; Aetna does not provide charity care; Blue Cross-Blue Shield does not. You stop paying your premium, your employer stops paying your premium, and you are out on your own. In this respect, we are absolutely no different from any other health care underwriters.

The fundamental difference between us and other health care underwriters is that we not only underwrite the cost, we also provide the mechanism by which the cost is dispensed. The refusal to let a member use a nonplan provider is pretty much like subscribing to the Sunday paper then going and buying the News American and expect the Sunday paper to pay for your News American. It is a contract between the member and us. There is no restriction on their freedom to go out and see somebody else, but it is not something they have purchased under that contract. It is not a matter of being callous or indifferent, it is a contractual agreement.

Dr. **Pierpont**. There is nothing the matter with what he says. The only trouble they do have a provider that furnishes you it for nothing but these chaps have never been asked to furnish anything for nothing.

You see, when I started, I took care of everybody. If it cost us money to do it, we did it, and I still do that. So indeed, you know, we do have some health care provides who still will furnish it for nothing. So the point is that what he is saying to you relative to getting into the system is true. Most of them, as I said before, have no idea what they have got. Believe me, the patient in my office has no idea what he has.

Mrs. **Bentley**. He shouldn't be in your office if he has an HMO contract, should he?

Dr. **Pierpont**. Well, we look after them anyway. We don't mind. We don't mind if he says yes, I belong to some HMO. They have taken me for some reasons, because I am cheap I guess.

Dr. **Martinez**. One of the joys of being on the panel with Ross Pierpont is that I may die of exhaustion but I will never die of boredom.

We provide each member at the time of enrollment with two documents. One is the legal contract and one is a booklet written in plain English, very simple English, a booklet I even can understand, which outlines what are his benefits and how to obtain them.

I think I sympathize with my colleagues because change is threatening, change is not something familiar and I can understand their misperceptions of what HMO's do. I am grateful for this opportunity to disperse some of these misperceptions.

Mrs. **Bentley**. Let me ask one other question of each of you. Forgetting that you are all physicians, and have ample income to cover your own health benefits, if you were a senior citizen, what form of coverage would you select to protect yourselves and your spouse knowing you would receive the best of care at the least minimal cost, what would you select?

Let's start with Dr. Martinez.

Dr. **Martinez**. Madam Chairman, it is a question that has many answers because the care one receives is as much a reflection of the system, the quality of the system, and the personal needs, of perceptions of the individual. I would say again, that if an elderly person does not depend emotionally on his relationship with his physician, and he is able to submit his or herself to the demands of a system called the HMO, I would advise them to join an HMO—specifically, Care First.

The question goes back to what I said before, we have a society that is strong because of its plurality and I hope that we can continue to maintain a plurality of systems.

Dr. **Reichel**. Yes, I would opt for a personal relationship with a private physician for myself or my family. There are many attributes to the HMO and PPO, and like Dr. Pierpont, I also belong to several, but I would say that the personal relationship between a private physician and the elderly patient is the most important thing. I am not certain what insurance systems would be available, but to try and make it as much of a personal bond between the two.

Just to throw out one other fact about giving a way of care, I heard at our State medical society meeting last week, Dr. Davis from North Carolina, a member of the board of trustees of the AMA, quoted a study that will be released by AMA, that cited that the average physician in America gives out 18,000 dollars' worth of free care in a year. I think that is a very important. Whether HMO's will allow that, they may not contractually be allowed to do that, but the average physician in America does give out 18,000 dollars' worth of free care per year.

Mrs. **Bentley**. He may do it through his private practice?

Dr. **Martinez**. I do it through private practice, indubitably.

Dr. **Pierpont**. May I just say that I believe that I would first, opt for catastrophic health care. If you put a floor of health care under, then I would offer individuals the ability to purchase what they want through a voucher system or whatever, not from Medicare, and let them be. If they minimize stumbling into something they don't like, they have made their own mistake, which is pretty much the American way of doing things, then I think you would have control over what you are going to spend and they would have the coverage when they got into real trouble.

Mrs. **Bentley**. Thank you very much. It has been an interesting panel.

We have with us our third panel, Mr. Kevin Moley, Acting Associate Administrator for Operations, Health Care Financing Administration, of Health and Human Services, which in plain english is Medicare.

PANEL THREE: CONSISTING OF KEVIN MOLEY, ACTING ASSOCIATE FOR OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY STEPHEN PELOVITZ, DEPUTY DIRECTOR, OFFICE OF RESEARCH AND DEMONSTRATION

STATEMENT OF KEVIN MOLEY

Mr. **Moley**. Yes, Congresswoman Bentley, I would like to say I am pleased to be here and I have with me the Deputy Director of our Office of Research and Demonstration, Mr. Stephen Pelovitz.

I will briefly summarize my statement, if I may. Medicare capitation, is a subject on which there is considerable interest today, Medicare payment to HMO's has been authorized since the program's inception. Initially, prepayment authority was restricted to part B. Prepayment organizations were permitted to receive 80 percent of their reasonable costs. HMO's could also elect to bill Medicare on a fee for service basis. Neither approach was consistent with the operating philosophy of HMO's, that is, to accept in advance a fixed per capita payment, regardless of the medical services actually rendered.

With the Social Security Amendments of 1972, some progress was made in providing a reimbursement mechanism consistent with HMO operation. In addition to a cost based reimbursement option, a modified risk basis option was made available. Under these contracts, the plan shared equally with Medicare in the savings it achieved up to 20 percent of total payments. However, payment was still made retrospectively and the final payment level was often not settled until years after services had been rendered.

In 1978, HCFA began to use its demonstration authority to develop prospective risk basis contracts. These demonstrations led to the enactment, in the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] of permanent authority for risk-sharing contracts for HMO's and competitive medical plans at 95 percent or the projected average per capita cost to Medicare for enrollees in the same geographic area under fee for service. That is what is known as the average adjusted per capita cost [AAPCC]. Under these TEFRA contracts, if the average payment rate is more than what the plan would charge, using its own commercial premium methodology, for the Medicare benefit package—that is, the plan's adjusted community rate—the organization cannot keep the difference. Generally, plans use these funds to provide Medicare enrollees with additional benefits, a reduction in premium, or some combination of the two.

We believe that the availability of these risk contracts is a historic turning point for Medicare. It marks a decisive move away from intrusive regulatory schemes for controlling costs to an approach that instead utilizes increased competition and consumer choice. It is through capitation that we will succeed in controlling costs while still providing high quality services.

We began signing contracts on April 1, 1985. As of March 31, 1986, we signed risk contracts with organizations in 28 States, covering over half a million enrollees. An additional 64 contracts, that would enable us to offer Medicare beneficiaries in seven other States an HMO/CMP option, are pending. In the State of Maryland, we currently have three TEFRA contracts that are projected to cover 7,600 Medicare beneficiaries by the end of 1986; one contract is pending.

Today, beneficiaries enrolled in HMO/CMP's are receiving both Medicare benefits and benefits not otherwise covered by Medicare, frequently for less than the average cost sharing under fee for service. We believe that this is an indication that everybody—the beneficiaries, the Federal Government and the American taxpayers—wins with capitation.

For example, all of the Maryland plans, in addition to the basic Medicare benefit package, provide unlimited hospital and skilled nursing facility days, preventive care and drugs. In addition, two of the plans provide eye care and extended mental health services. For two of the plans, enrollees receive these additional benefits for a monthly premium that is at least $17 less than the projected average cost sharing for the basic Medicare benefit package under fee for service. In the third plan these additional benefits, which are more extensive than those provided under most MediGap plans, cost $10 more than the projected average fee for service cost sharing.

Because we are convinced that capitation is the answer to the health care reform, we are proposing to build on the existing TEFRA options through a voluntary voucher system. Our proposal would:

Expand the pool of entities that could qualify for capitated payments by allowing indemnity insurers as well as HMO's and CMP's to provide alternative coverage.

Make enrollment in private plans more attractive to beneficiaries by allowing employers to combine the Medicare payment with their own premiums for annuitants to secure a uniform plan without duplicative coverage.

Eliminate certain current requirements that are overly rigid, such as the requirement that HMO's and CMP's offer the actual Medicare benefit package. Subject to a test of actuarial equivalence of benefits, plans would be free to restructure the Medicare benefit package.

Insurers have expressed interest in becoming health benefit plans under our voucher proposal. In addition, some major employers and unions have developed or are in the process of developing plans to be at risk for the Medicare benefit package for their annuitants.

In addition to our voucher proposal, we are considering among other possible alternatives, the demonstration of a geographic capitation approach. In contrast to an HMO or CMP that serves only those individuals who enroll in it, under geographic capitation an entity would be responsible for ensuring the provision of benefits to all beneficiaries in a geographic area. The entity would offer a number of options to beneficiaries, including traditional Medicare as well as options incorporating components of preferred provider organizations.

In order to be eligible to enter into a risk contract with Medicare, a HMO must meet the conditions specified in State law and the standards for Federal qualification under title XII of the Public Health Service Act. For competitive medical plans [CMP] an organization must be determined to meet the statutory definition, which includes the requirement that it be organized under State law.

For all practical purposes, under Medicare, HMO's and CMP's are the same. That is, entities that provide a full range of health care on a prepaid capitation basis. Both HMO's and CMP's must have at least 5,000 non-Medicare enrollees or 1500 if it serves a primarily rural area. They must also have at least 75 Medicare enrollees or an acceptable plan to achieve this membership within 2 years.

Finally, and we believe that this is extremely important, no more than 50 percent of the plan's enrollment can be Medicare and Medicaid beneficiaries. The 50-percent rule is crucial because it assures that before any plan can contract with Medicare, it must have already demonstrated that it can meet the rigors of the market by attracting and retaining a significant commercial enrollment.

We are notifying the central office here in Baltimore, and every Medicare beneficiary who chooses to enroll in one of our TEFRA risk contracts, of their rights under Medicare, that they are still remaining within the Medicare system, and that finally, we in fact are explaining the plans explanation of the details of the lock-in provision.

We feel it is very important that beneficiaries recognize the initial benefits they are receiving. In fact, they are losing some freedom of choice, by joining such a prepaid operation. There is in fact both benefits and once again, there are some to lock in provisions by virtue of joining such an organization.

Mrs. BENTLEY. While you are on that subject, will you explain that a little more in detail, on what is a lock-in provision, how does it affect the purchaser, and can they get out of it. What does Medicare give them?

Mr. MOLEY. That is a good point, Congresswoman, it is something that we are striving mightily to make sure that all Medicare beneficiaries who choose to join such organizations clearly understand. When a Medicare enrollee chooses to join an HMO, they in fact are contracting to have their services, their Medicare services, provided throughout that organization. Except in two cases. When they require emergency care, or when they are outside of the planned area which is covered by that HMO, or a competitive medical plan in which case they can obtain services in any fashion that they so require.

However, if they are at home, within the plan's service area, we say contracted for joint HMO, they must use the services of the HMO or competitive medical plan, or they will not be reimbursed. So obviously it is essential that we explain to them by requiring (a) that the plan explains it to them, and (b), by notification from HCFA central office what those lock-in provisions are.

Mrs. BENTLEY. Let's say they join an HMO in January, and they decide by June that they don't want to belong to it anymore, can they get out of it and will Medicare still cover them?

Mr. MOLEY. Yes. As a matter of fact, unlike the provisions which affect Federal employees, Congresswoman, when and if a Federal employee chooses to join an HMO or competitive medical plan they are locked in for the number of years. In fact, Medicaid beneficiaries has the opportunity if they at any time are not pleased with the care they are receiving or for any reason they desire to leave the HMO or competitive medical plan, they have the right to immediately disenroll. If they were disenrolled today for instance, that enrollment would become effective on of May 1. They in fact, can disenroll within 30 days at any time they are a member, after they have enrolled, they have the right to disenroll immediately.

Mrs. BENTLEY. Their Medicare coverage is not affected?

Mr. MOLEY. Medicare coverage immediately goes back into effect on the first of the month following their notification of intent to disenroll.

Mrs. BENTLEY. Are they locked in to that HMO, if they are paying what we heard the figure of $41 a month that they are a paying out, plus the $15.50 a month they are paying for Medicare, why are they locked into that, why can't they go to anywhere like any Medicare person if they want to?

Mr. Moley. The benefits of HMO are based on the HMO's ability to manage care. That is to prescribe the facility which most accurately can provide care and services for that beneficiary based on their physical condition. If you look at the benefits of managing that care, and then you are right back into the traditional fee for services system of people choosing to get care from wherefore source they want to, without the benefit of having managed care.

On the other hand, of course, Congresswoman, it is essential to remember that when these beneficiaries are joining HMO's in competitive medical plans are most often for the additional benefits, the benefits over and above the Medicare package that are becoming available to them, by virtue of having joined the organization.

We believe that our capitation programs are working to the benefit of both our beneficiaries and the Federal Government. Our continued progress depends on maintaining the confidence of Medicare and Medicaid beneficiaries. We all continue to work with Congress, beneficiary groups, and the provider community toward the end of strengthening that trust.

With our new emphasis on capitation, Medicare and Medicaid have embarked toward a system of cost effective quality care provided in a competitive environment. By the start of the next century, the health care marketplace will look very different than it does today. Through the expansion of options, beneficiary choice will have a greater impact on the market, and that is where the locus of decision making rightfully belongs.

I thank you for the opportunity to discuss these issues with you. I would be happy to respond to any questions that you may have.

[The prepared statement of Mr. Moley follows; along with a prepared statement of Otis R. Bowen, Secretary, Health and Human Services, delivered to the House Select Committee on Aging, Subcommittee on Health and Long-Term Care, February 19, 1986:]

PREPARED STATEMENT OF KEVIN MOLEY, ACTING ASSOCIATE ADMINISTRATOR FOR OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH & HUMAN SERVICES

I am pleased to be here today to discuss the administration of our capitation programs under Medicare and Medicaid. I had also been asked to address the Administration's initiative in the area of protection against catastrophic health care costs. Secretary Bowen recently testified before the Subcommittee on Health and Long-term Care of the House Select Committee on Aging on this subject. The Secretary carefully outlined the Administration's interest in this area and the steps that are being taken to meet the deadline set out by the President in his State of the Union Address. I have provided a copy of his testimony for the record.

MEDICARE CAPITATION

Medicare payment to HMOs has been authorized since the program's inception. Initially, prepayment authority was restricted to Part B. Prepayment organizations were permitted to receive 80 percent of their reasonable costs. HMOs could also elect to bill Medicare on a fee-for-service basis. Neither approach was consistent with the operating philosophy of HMOs, that is, to accept in advance a fixed per capita payment, regardless of the medical services actually rendered.

With the Social Security Amendments of 1972, some progress was made in providing a reimbursement mechanism consistent with HMO operation. In addition to a cost-based reimbursement option, a modified risk basis option was made available. Under these contracts, the plan shared equally with Medicare in the savings it achieved up to 20 percent of total payments. However, payment was still made retrospectively and the final payment level was often not settled until years after services had been rendered.

TEFRA RISK CONTRACTS

In 1978, HCFA began to use its demonstration authority to develop prospective risk basis contracts. These demonstrations led to the enactment, in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), of permanent authority for risk sharing contracts for HMOs and competitive medical plans (CMPs) at 95 percent of the projected average per capita cost to Medicare for enrollees in the same geographic area under fee for service — that is, what is known as the average adjusted per capita cost (AAPCC). Under these TEFRA contracts, if the average payment rate is more than what the plan would charge, using its own commercial premium methodology, for the Medicare benefit package — that is, the plan's adjusted community rate — the organization cannot keep the difference. Generally, plans use these funds to provide Medicare enrollees with additional benefits, a reduction in premium or some combination of the two.

We believe that the availability of these risk contracts is a historic turning point for Medicare. It marks a decisive move away from intrusive regulatory schemes for controlling costs to an approach that instead utilizes increased competition and consumer choice. It is through capitation that we will succeed in controlling costs while still providing high quality services.

We began signing contracts on April 1, 1985. As of March 31, 1986, we signed 119 risk contracts with organizations in 28 states, covering over half a million enrollees. An additional 64 contracts, that would enable us to offer Medicare beneficiaries in 7 other states a HMO/CMP option, are pending. In the state of Maryland, we currently have 3 TEFRA contracts that are projected to cover 7,600 Medicare beneficiaries by the end of 1986; one contract is pending.

Today, beneficiaries enrolled in HMO/CMPs are receiving both Medicare benefits and benefits not otherwise covered by Medicare, frequently for less than the average cost sharing under fee-for-service. We believe that this is an indication that everyone — the beneficiaries, the Federal government and American taxpayers — wins with capitation.

For example, all of the Maryland plans, in addition to the basic Medicare benefit package, provide unlimited hospital and skilled nursing facility days, preventive care and drugs. In addition, two of the plans provide eye care and extended mental health services. For two of the plans, enrollees receive these additional benefits for a monthly premium that is at least $17 less than the projected average cost sharing for the basic Medicare benefit package under fee-for-service. In the third plan these additional benefits, which are more extensive than those provided under most Medigap plans, cost $10 more than the projected average fee-for-service cost sharing.

Because we are convinced that capitation is the answer to health care

Until recently, the Office of Health Maintenance Organizations (OHMO) in the Public Health Service made the determinations as to whether an HMO/CMP was Federally qualified, while the Health Care Financing Administration had the responsibility for entering into Medicare risk contracts. As you may be aware, Secretary Bowen recently approved the transfer of OHMO from the Public Health Service into HCFA. The Secretary believes this transfer will:

- improve the operations of both the HMO program and Medicare HMO/CMP contracting;

- give wider visibility to the Administration's efforts to promote capitation programs; and

- facilitate communications with a broader base of organizations interested in applying for Medicare HMO/CMP contracts.

MEDICAID CAPITATION

Any discussion of capitation under the Medicaid program has to consider the significant differences between Medicare and Medicaid which present difficulties in the development of capitation options.

- The Medicaid population tends to be unstable in regard to program eligibility. Recipients also typically have high service use when they first enter a prepaid plan.

- Medicaid serves two distinct populations with very different medical needs — families with children and the aged, blind and disabled.

- The highest cost recipients come on to the Medicaid roles because they are sick and leave the rolls when they no longer need care.

- Nursing home care accounts for 44 percent of Medicaid program costs.

A combination of the recession and other pressures to reduce health care costs in the early 1980's prompted States to explore ways to reduce their program budgets without adversely affecting recipients through alternatives to the traditional fee-for-service delivery system. Prior to the enactment of the Omnibus Budget Reconciliation Act of prepaid capitation basis. Both HMOs and CMPs must have at least 5,000 non-Medicare enrollees or 1,500 if it serves a primarily rural area. They must also have at least 75 Medicare enrollees or an acceptable plan to achieve this membership within 2 years. Finally, and we believe that this is extremely important, no more than 50 percent of the plan's enrollment can be Medicare and Medicaid beneficiaries. The 50 percent rule is crucial because it assures that before any plan can contract with Medicare, it must have already demonstrated that it can meet the rigors of the market by attracting and retaining a significant commercial enrollment.

In addition to these general conditions, the qualifying conditions for a Medicare risk contract cover five other areas. They are:

- Administration and Management - The organization must demonstrate that it has sufficient administrative capability to carry out the requirements of the contract and that it has no agents, management staff or persons with ownership interests who have been convicted of criminal offenses related to their involvement in Medicare or Medicaid or other Social Security Act programs.

- Operating Experience and Enrollment - The organization must demonstrate that it has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a prospective per capita reimbursement rate.

- Range of Services - The organization must demonstrate that it is capable of delivering to Medicare enrollees the range of required services, i.e., all Part A and Part B services.

- Furnishing Services - The organization must furnish the required services to its Medicare enrollees through Medicare certified providers and suppliers. It must also ensure that all services for which the Medicare enrollee has contracted are available and accessible and are furnished in a manner that ensures continuity.
- Quality Assurance Program - The organization must have an acceptable quality assurance program.

Each plan that meets the qualifying conditions is allowed to enter the Medicare market. Beneficiary choice and the rigors of the market will determine which organizations succeed.

reform, we are proposing to build on the existing TEFRA options through a voluntary voucher system. Our proposal would:

- Expand the pool of entities that could qualify for capitated payments by allowing indemnity insurers as well as HMOs and CMPs to provide alternative coverage;

- Make enrollment in private plans more attractive to beneficiaries by allowing employers to combine the Medicare payment with their own premiums for annuitants to secure a uniform plan without duplicative coverage, and

- Eliminate certain current requirements that are overly rigid, such as the requirement that HMOs and CMPs offer the actual Medicare benefit package. Subject to a test of actuarial equivalence of benefits, plans would be free to restructure the Medicare benefit package.

Insurers have expressed interest in becoming health benefit plans under our voucher proposal. In addition, some major employers and unions have developed or are in the process of developing plans to be at-risk for the Medicare benefit package for their annuitants.

In addition to our voucher proposal, we are considering, among other possible alternatives, the demonstration of a geographic capitation approach. In contrast to an HMO or CMP that serves only those individuals who enroll in it, under geographic capitation an entity would be responsible for ensuring the provision of benefits to all beneficiaries in a geographic area. The entity would offer a number of options to beneficiaries including traditional Medicare as well as options incorporating components of preferred provider organizations.

QUALIFYING CONDITIONS FOR RISK CONTRACTS

In order to be eligible to enter into a risk contract with Medicare, a HMO must meet the conditions specified in State law and the standards for Federal qualification under Title XIII of the Public Health Service Act. For Competitive Medical Plans (CMPs), an organization must be determined to meet the statutory definition, which includes the requirement that it be organized under State law.

For all practical purposes under Medicare, HMO's and CMP's are the same — that is, entities that provide a full range of health care on a

1981 (OBRA), States could utilize prepaid health plans for Medicaid beneficiaries in most instances only if enrollment was voluntary and providers were generally Federally qualified HMOs with no more than 50 percent Medicaid and Medicare enrollment or were community health centers receiving Public Health Service funds. Alternatively, States could apply to be granted a formal demonstration project by HCFA which involved rigorous research design and requirements.

With the enactment of OBRA, States were permitted to establish their own HMO qualification standards and were allowed contracts with HMOs which had up to 75 percent Medicaid and Medicare enrollment. Additionally, OBRA authorized the Secretary to grant waivers of Federal Medicaid requirements for beneficiary "freedom of choice" where necessary to permit States to establish primary care case management systems for their Medicaid recipients and to select Medicaid providers based on their cost effectiveness.

A number of States have utilized the freedom of choice waiver authority to implement new approaches with the goals to link recipients with ongoing, coordinated primary care; reduce use of expensive inpatient and emergency room care, prescription drugs and lab tests; and to improve access to both routine and urgent primary care. There are also a number of States which have utilized formal HCFA demonstration waiver authority to implement capitated programs.

QUALIFYING CONDITIONS FOR CAPITATED PAYMENTS

For Medicaid purposes, an entity is considered to be an HMO if it provides, on a risk basis, either:

- Inpatient hospital services and at least one of the five non-inpatient mandatory services; or
- Three or more of the mandatory non-inpatient services.

States may enter into a contract with an organization meeting this test provided that:

- It is a Federally qualified or State qualified HMO;
- Not more than 75 percent of its enrollment is Medicaid and Medicare beneficiaries;
- The reimbursement rate is actuarially sound;

- The Secretary and the State have the right to audit the plan;

- Enrollment and disenrollment may not involve discrimination on the basis of health status or requirements for services;

- Members have the right to disenroll at any time on one month's notice; and

- Members must be reimbursed for emergency services provided outside of plan.

Recent legislation has differentiated Federally qualified HMOs from State qualified HMOs, putting less restrictions on plans in the former category.

In addition to HMOs, prepaid health plans (PHPs) can receive capitated payments. Since PHPs are almost exclusively Public Health Service Community Health Centers, they are exempt from some of the contracting requirements that apply to HMOs. Also, States can contract with health insuring organizations (HIOs) which receive a monthly per capita payment to underwrite the costs of providing benefits to recipients. An HIO differs from an HMO or a PHP in that it pays for services whereas an HMO or a PHP actually provides the services. While previously exempt, new HIOs must meet the contracting requirements of HMOs as a result of the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985.

As of December 1985, a total of close to 700,000 Medicaid beneficiaries were enrolled in 130 HMOs and PHPs. This is a substantial increase from the previous year when close to 500,000 were enrolled. As of April 1, 1986, in Maryland, capitation payments were being provided for close to 19,000 Medicaid beneficiaries enrolled in 3 HMOs and 2 PHPs.

As with Medicare, capitation in Medicaid provides a means to control both the price and utilization of services while maintaining high quality care. We anticipate continued significant growth in enrollment in these plans.

CONCLUSION

We believe that our capitation programs are working to the benefit of both our beneficiaries and the Federal government. Our continued progress depends on maintaining the confidence of Medicare and Medicaid beneficiaries. We will continue to work with Congress.

Beneficiary groups and the provider community toward the end of strengthening that trust.

With our new emphasis on capitation, Medicare and Medicaid have embarked toward a system of cost effective quality care provided in a competitive environment. By the start of the next century, the health care market place will look very different than it does today. Through the expansion of options, beneficiary choice will have a greater impact on that market, and that is where the locus of decision making rightfully belongs.

I thank you for the opportunity to discuss these issues with you. I'd be happy to respond to any questions that you may have.

PREPARED STATEMENT OF OTIS R. BOWEN, SECRETARY, HEALTH AND HUMAN SERVICES, BEFORE THE HOUSE SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, FEBRUARY 19, 1986

Good morning Mr. Chairman. I am honored by your invitation to speak here today, and I am pleased that my first appearance on Capitol Hill as Secretary of the Department of Health and Human Services is before the House Subcommittee on Health and Long-Term Care.

Chairman Pepper, your life is chapter and verse a wonderful chronicle of hard work and sacrifice dedicated to the public good. As the oldest member of Congress, you have a well-recognized and special interest in the needs of elderly Americans, and I am always willing to listen very carefully to your advice.

I would also like to take a moment to recognize the efforts of the Ranking Minority Member of this Subcommittee, Representative Ralph Regula. Your compassion for our most needy and fragile citizens is a credit to this Congress, and strikes the highest ideals of public service.

Today I will give you a brief overview on the status of aging in America, and I will touch on our study of catastrophic health care. I would point out, however, that we have not yet decided the parameters and timetables of this study. Following my presentation, Mr. Thomas R. Burke, the new HHS Chief of Staff, will elaborate on my discussion.

Mr. Chairman, as a family practice physician I have ministered to many of my elderly friends and neighbors in Indiana. I know that while good health was vital, most of them were also fearful of losing their independence. With this in mind, as Governor of Indiana I labored to strike a balance between government serving the needs of people and government protecting their freedom and independence. I will work to forge the same balance at HHS.

Mr. Chairman, these are golden years, filled with hope for the future of our older Americans. Let me give you some examples:

A recent report released by my Department shows that life expectancy in the United States is at a record high. In 1983 the life expectancy at birth reached 74.6 years, roughly an increase of over 27 years since the turn of the century.

America's older Americans are leading healthier lifestyles, and many have tremendous energy and vitality. The President's demanding lifestyle is a constant example of rigorous vitality, and I'm sure Chairman Pepper would be the first to agree that life doesn't stop at 65 -- and I'm glad it doesn't because in one week I will be 68.

There are many reasons for these changes. Our Social Security system and public health care financing in the form of Medicare and Medicaid have certainly played a part. We must also give credit to a strong economy that bolsters investments and holds down inflation for those on fixed incomes, stretching the value of their savings.

It is in this spirit that the President's 1987 budget proposal calls for a full cost-of-living increase of 3.7 percent for those on Social Security.

Also, older Americans are receiving the benefits of new applications of technology. New technological achievements have made it possible to replace fragile hips and knee-joints. Innovative techniques now make operations more successful with less discomfort, such as new methods of lens replacement or implants which quickly improve sight.

In fact, many of our elderly are now going back to school to study the arts, philosophy, and the sciences. They are running for office, staying on the job longer, and contributing to our economy and culture in numbers that are unprecedented.

Our public policies must reflect these new demographic changes. We must have the foresight to adapt to an increasingly larger number of older citizens. Government programs, many of which were designed when the elderly population was small, must be examined to reflect these modern day demographics.

As more people live longer, health, social, economic and other problems associated with aging change. For example, the demand for medical care is certain to rise.

It is estimated that the elderly will make about 230 million visits to physicians annually by the end of the century. There were about 165 million such visits in 1980. The projected increase is about 40 percent. This shows graphically that, although the numbers of elderly will increase steadily, the projected costs of health care will increase geometrically.

The potential impact on hospital and nursing home care is even greater. Persons 65 years of age and older may use about 160 million days of care in short-term hospitals in the year 2000, a gain of 55 million days over the 1980 level. This increase in utilization is over 50 percent.

We have had almost a generation of experience with most of our Federal health and human services programs. We can now measure the ideals of the legislation verses the reality of their operation. We now have empirical evidence that contrasts our intentions with factual results. This is why the President called for two important studies affecting my department.

First, in the State of the Union address the President called for an examination of how the private sector and the government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes. We are enthusiastic about his charge to examine the entire question of catastrophic illness costs -- including possible actions for both the private and public sectors.

The second study, an examination of welfare policy, is equally important, and will be the subject of considerable scrutiny.

Our work is just beginning. This hearing, and your interest, could not be more timely.

Thank you again for this opportunity to speak with you.

PREPARED STATEMENT OF THOMAS R. BURKE, CHIEF OF STAFF, DEPARTMENT OF HEALTH AND HUMAN SERVICES, BEFORE THE HOUSE SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, FEBRUARY 19, 1986

Mr. Chairman, I would like to thank you, Representative Regula, and the distinguished members of the House Subcommittee on Health and Long-term Care for allowing me the opportunity to discuss the problems of catastrophic illness costs, and the commitment by the Reagan Administration to seek appropriate solutions to this multi-faceted problem.

Mr. Chairman, I'm sure all of us will agree that no American ought to face financial ruin because of the necessity of medical care. But, beyond that assertion, there is very little consensus about how to accomplish this task.

In fact, there is often little agreement on what constitutes a catastrophic medical cost.

For example, some have defined it as a large aggregate dollar cost, perhaps $20,000 and above. Others say it depends on the size of patient out-of-pocket expenses, somewhere above $2,000. Still others relate it to the cost incurred and the individual's income.

While each of these definitions has merit, they often do not take into account such important variables as net worth and outstanding indebtedness.

Mr. Chairman, I know that the members of this Subcommittee are aware that health care can be very expensive. For some a hospital stay can cost tens of thousands of dollars, and often run into the hundreds of thousands of dollars.

The cost of any illness that entails long-term care may be even greater. For example, in 1983 Americans spent $27.3 billion on nursing home care, and we estimate that this figure will soar to $83 billion by 1990. And consider this: unlike hospital care, little of the cost of nursing home care is paid by private insurance. While 45 percent of the 1983 nursing home bill was paid from private sources, only 1.6 percent came from insurance.

Parenthetically, almost half of the total nursing home care costs, over $13 billion, were paid by Medicaid.

The need for long-term care may drain precious savings away from the elderly and their families, and some may lose a lifetime's struggle for financial security and independance.

In addition, once expensive care is required the need rarely diminishes: one-fifth of the affected families will experience large medical expenses once again in the next year, and most will do it again a third year.

Even if those who need care hold on to some of their savings, no one can predict when debilitating illness will strike. Many of our elderly live in fear, waiting for the nightmare of catastrophic illness to wipe them out.

Of course, many have private insurance, and they are wise if they have coverage for catastrophic care. However, too often catastrophic care is not a part of the policy, or coverage is too limited to be adequate.

Within the Medicare population alone, each year approximately 12,800 beneficiaries exhaust their lifetime reserve days for hospital coverage and 280,000 beneficiaries experience hospital stays which exceed the 60-day limit at which point large cost-sharing begins.

Let me amplify the problems faced by the beneficiaries. Private insurance goes part of the way in picking up coverage after Medicare leaves off; 30 percent of beneficiaries have full coverage after the expiration of the lifetime reserve days, and 15 percent have partial coverage through private insurers. In addition, 38 percent of beneficiaries have private coverage cost-sharing after the 60th day in the hospital.

But this still leaves a small minority with little or no coverage for extended hospital stays.

This problem can only get worse with the "graying of America". An estimated 6.6 million Americans 65 years of age and older now require long-term care, and that number will reach 9.1 million by the end of the century. This trend will continue geometrically.

Many elderly people think they are fully protected by Medicare. But Medicare covers only a portion of the costs of acute hospital care and physicians' services for those 65 and over, and does not cover long-term care.

Mr. Chairman, we are faced with a new and sobering challenge: to discover better forms of coverage. We must find forms of coverage that are efficient and encourage quality care without sacrificing efficiency, that are affordable for the American taxpayer, that will not further deplete older Americans' savings, and that will not add to the current Federal deficit problem.

Mr. Chairman, the President has asked in his recent State of the Union address for Secretary Bowen and the Department of Health and Human Services to report by year's end with recommendations on how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes. This is a challenge that we welcome.

The President's charge is a clear indication that the White House is willing to work with the private sector, with other levels of government, and with the Congress to explore innovative, creative and serious proposals for catastrophic care coverage.

Secretary Bowen and I have a keen interest in this subject. It is one we discussed when Dr. Bowen was Chairman of the President's Advisory Council on Social Security, and was the subject of an article we co-authored before the Secretary was asked by the President to assume the mantle at HHS.

In that article we considered an optional plan to add a $11 a month premium to the $15.50 monthly premium already charged for Medicare coverage. Expanded Medicare coverage would ease the strain on individual participant's savings, and take some of the fiscal pressure off the Medicaid program.

A second part of that proposal would establish Individual Medical Accounts (IMAs) for financing chronic care expenses. This concept, based on the success of Individual Retirement Accounts (IRAs), would allow tax-deferred contributions to a government "health bank" administered by the private sector.

As I stated, Dr. Bowen and I made that proposal before the Secretary was confirmed. We plan to treat it as a proposal worthy of intense examination, but we are not recommending its passage at this time. It shall be considered in light of the President's broader charge to examine the role of the private and public sectors in providing catastrophic coverage.

We are not locked into any proposal. I know that Secretary Bowen plans to examine all of the available information, scrutinize every proposal, and consult this Subcommittee, other members of Congress, medical and consumer groups, and others in the Administration before he formulates his final report to the President.

That is why these hearings are important. We are looking to the Congress to help us gather information. We plan to listen very closely to the testimony presented here, and we will have an open mind as we examine all alternatives.

Thank you for the opportunity to share a few moments with you this morning, and I commend this Subcommittee for its diligent and compassionate work to highlight one of our most important national concerns.

I will be happy to respond to any questions you may have at this time.

Mrs. **Bentley**. I will give Congressman Blaz the first questions.

Mr. **Blaz**. I would like to go to the volunteer voucher proposal that has a fascinating twist to it. Would you tell me where it is right now, what stages it is in. It is a new one?

Mr. **Moley**. Yes, indeed, Congressman. Senator David Durenberger, Republican from Minnesota, introduced the administration's volunteer voucher bill in the Senate on December 1985 and it stirred such considerable interest in the health care policy making circles. In fact as I emphasized earlier, it is a volunteer voucher proposal, and its primary thrust would be to make available to Medicare beneficiaries a wider option of choices—that is currently under TEFRA—the Medicare beneficiaries have the option of joining a federally qualified Medicare contracted health maintenance organization or competitive medical plan.

It does not have the right to be offered benefits through a traditional indemnity insurance carrier and the volunteer voucher bill would make it available to a wider option of organization to participate in trying to enroll Medicare beneficiaries. We very strongly believe that the enticement to enrolled Medicare beneficiaries will end up providing additional benefits to those Medicare beneficiaries at little or no additional cost to the Federal Government. That is most important.

As I indicated earlier, we would be paying to these organizations as we pay not to HMO's and CMP, 93 percent of the average adjusted per capital cost. What that means is that if you took all the Medicare beneficiaries in the Nation, divided that number into the total amount of money which we are spending on Medicare, you would come up with an average adjusted per capita cost for that individual. We are discounting that by 5 percent. That is the amount of 95 percent of average adjusted per capita costs which we are paying to these organizations, mandating that they provide the Medicare package of benefits. As I said, virtually all of them are providing additional benefits as a way of encouraging and enticing Medicare beneficiaries to enroll in their organization.

Mr. **Blaz**. Let me ask you another questions. This doesn't have anything to do necessarily with your testimony, but let me ask you your thought on this.

Witness after witness would come before panels such as this, hearings such as this, and state that the Medicare health care for the aging is inadequate and Medicare itself has been maligned, et cetera, et cetera, and yet in the same breath when they say they are not taken care of three, they base the points that in such and such a year coming down the pike, say 2000 to 2020, we are going to have larger problems because medical care is so good people are living longer.

Now, in my mind, it is difficult to resolve on the one hand the case we are not doing too well, and on the other hand, we have to do something because people are living longer because we are doing so well. Would you care to comment?

Mr. **Moley**. I think, Congressman, this is a classic case of a possible misperception of where we are as opposed to where we would like to be. I think everyone, virtually everyone in the room would agree our system of medical care is unexcelled everywhere in the world. That is not to say it can't stand improvement. That is not to say in certain specific areas there may be some nation or geographic area that maybe do slightly better, but given the extent of our population, given the extent of the services that we are providing, that it is clearly the case that our health care delivery system is unexcelled.

The problem, however, is that it is not only excellent, but it is extraordinarily expensive and we have the unfortunate situation of having to live within our means. As you know, the trust fund for Medicare is projected now to run out as early as 1996 or 1997. So it behooves all of us to try to find ways to continue the benefits of our system, however continuing them in a way that we will be able to continue to afford this system.

We believe the route to go is through capitation. We believe that our goal in the Federal Government currently is to encourage competition through capitation and that the American public will better be served by a pluralistic health care delivery system where health maintenance organizations, competitive medical plans, preferred provider organizations, health indemnity insurance carriers, are all competing to enroll Medicare beneficiaries, and that the Medicare beneficiary has an opportunity to make the same choices as employers and employees in the under age 65 market are able to do now.

Mr. BLAZ. You are tenacious in the capitation stuff.

Let me ask you one more question. This morning we had a number of witnesses who stated that the administrators of health care, Medicare, whatever, HMO's, are frequently quite callous, and they are heartless, more interested in getting the forms and getting people processed. This is a very common allegation. As a matter of fact, in my own experience, I find that difficult to believe, because I have seen those people who gravitate toward jobs such as those are usually the one who have a certain affinity for taking care of people. Yet the allegation persists. Are you in a position to comment on whether or not these allegations are, say plentiful, or are they just infrequent?

Mr. MOLEY. We don't believe they would be systemic. However, in a system as large as ours and with as many providers as we have, in doctors, hospitals, clinics, nurses, et cetera, there are bound to be those who are not operating under incentives provided by society to provide good quality care, and for that we have established in every State, and in the terroritories, some——

Mr. BLAZ. Thank you.

Mr. MOLEY [continuing]. Some 54 peer review organizations. Those peer review organizations were originally set up under the per diem payment system to look primarily at utilization. We have discovered that it is in our best interests now to refocus their efforts to look at the quality of care that is being delivered.

There have been allegations that under respective payments that patients are being discharged quicker and sicker. In fact, they may be being discharged, as a matter of fact, most definitely are being discharged quicker, and they may not be as well as they have been discharged in the past. Where we have to focus our attention is are they sick enough to remain in the hospital, are they being discharged prematurely.

Evidence to date suggests that there are only anecdotal problems, they are not systemic problems. However, in recontracting with those 54 peer review organizations, which we are doing over the course of this spring and summer, we are refocusing their activity toward looking at the quality of care.

We previously have looked at readmissions to hospitals within 7 days, for instance, to determine if Medicare beneficiaries who are being discharged, were having to be readmitted by virtue of the fact that they had been prematurely discharged. We are now stretching that out so that we can look at discharges that occur from the day of discharge all the way out to 14 days, so we can see if we catch more of this and see in fact if we have a problem in that regard.

As I said, to date, the problems we have heard are anecdotal and do not reflect a systemic problem with our health care delivery system.

Mr. **Blaz**. Thank you. You are a very persuasive witness, Mr. Moley and you are not aged.

Mr. **Moley**. I have a lot more gray hairs since I took this job.

Mrs. **Bentley**. Well, you may have a lot more before you are finished, too.

You talk about capitation and the importance of it, and the one thing that bothers me about it is that there is no differentiation in age in regard to illnesses as to how many days a person should or should not be kept in a hospital. It is just a flat 5 days for a heart condition, certain heart conditions, or 10 days for something else, or 7 days for this, but it doesn't make any difference if a person is 25 or the person is 70. That does bother me a great deal.

Mr. **Moley**. That is one of the reasons why we are so high on capitation, because in fact, although what you say is true under the current respective payment system, under capitation, we pay to that HMO competitive medical plan—I may have oversimplified Medicare, saying 95 percent of the adjusted per capita cost. In fact, what we do is we pay 120 different rates per county in the United States based on the section, and the institutional staffs, whether that individual Medicare beneficiary is institutionalized or noninstitutionalized. So in fact, under our method of payments for capitated services, we go a long way toward taking into account the variety of ages in the elderly marketplace.

As you said, that is not taking into account in the same way under respective payment but we are making an effort in our payment methodology to health maintenance organizations and health medical plans to take that into account.

Mrs. **Bentley**. I hope you do. I think that is a very important point to make. There is no way that a person who is over 65 or 75 or 80, can heal as quickly as somebody who is 20 or 25, and I think the failure to do that over the years has been wrong.

You said all Maryland plans provide unlimited hospital and skilled nursing facility days. Were you referring only to HMO's there?

Mr. **Moley**. Yes, ma'am. The HMO's that have contracted with us so far, to date in Maryland, have in fact provided unlimited hospitals days as one of their benefits to entice Medicare beneficiaries to join their plan.

Mrs. **Bentley**. Well then, why are some of our people put out of the hospitals in 4 days, 5 days? We had some very glaring examples of people who had both legs cut off and just sent home callously, without any help, put in the ambulance and sent home. We have had that this morning. What you are saying and what they said doesn't add up.

Mr. **Moley**. I did not hear the prior testimony but I believe they must have been referring not to care that they were seeing.

Mrs. **Bentley**. Medicare.

Mr. **Moley**. Exactly, they may have been referring to Medicare, not specifically to care given to them by an HMO or a competitive medical plan. Maryland, as you know, has a slightly different system. As a matter of fact, actually a substantially different system, although in their sense may be somewhat similar. I am afraid we would probably have to refer you to the Maryland Health Services Cost Review Commission.

Mrs. **Bentley**. I am familiar with them.

Mr. **Moley**. We are aware, Congresswoman, however, that there are no facts, allegations of some premature discharges under respective payment system. Respective payment system has gone a long way toward setting the stage for competition, it has not been without problems, but as I indicated earlier, data to date does not reflect systemic problems but individual problems. Some of these individual problems are quite glaring in nature. Of course, we regret them, but I think we have to keep them in the context of a larger providers delivery system.

Mrs. **Bentley**. Well, in summary, I will reemphasize to you how important I believe it is that HHS totally look into the matter of limiting the days for the 25-year-old, or the 65-year-old the same as the 25-year-old, I just think that is wrong, and that cannot be taken care of too soon.

Mr. **Moley**. Congresswoman, we at HHS are aware of your longstanding commitment to the elderly and we will most definitely be conscious of your concerns in regard to the differentiations between days for the elderly in terms of the difference between 65 years and 70 year olds which can often be quite grave.

Thank you.

Mrs. **Bentley**. Thank you for coming this morning.

We will now break for lunch. We are running a little over, so instead of coming back at 12:45, we will come back at 1 o'clock.

[Whereupon, at 12 noon, the subcommittee was recessed to reconvene at 1 p.m., the afternoon of the same day.]

AFTERNOON SESSION

Mrs. **Bentley**. We will start the afternoon session with witnesses from the insurance end of the industry, and we have with us, Mr. Howard Richmond from the Maryland State Insurance Division and Al Baker, who is with the Chesapeake Health Plan. He will be joined by Mr. Joseph La Asmar shortly. We will hear first from Mr. Richmond.

PANEL FOUR: CONSISTING OF HOWARD RICHMOND, CHIEF INVESTIGATOR, LIFE AND HEALTH, MARYLAND INSURANCE DIVISION; AND JOSEPH LA ASMAR, PRESIDENT, CHESAPEAKE HEALTH PLAN, ACCOMPANIED BY AL BAKER

STATEMENT OF HOWARD RICHMOND

Mr. RICHMOND. Thank you.

My name is Howard Richmond, I am chief investigator, life and health, for the Maryland Insurance Division. As you may know, our division is charged with regulating the business of insurance in the State of Maryland. My duties include investigating and responding to complaints and inquiries about all areas of health insurance, including Medicare supplement coverage.

What is the MediGap policy?

The Maryland Insurance Code section 468(b) gives this definition: "A policy of health insurance primarily designed to supplement Medicare, or advertised, marketed, or otherwise purported to be a supplement to Medicare coverage."

Are Medicare supplement and MediGap specific terms, or are they general in nature?

Prior to 1980, abuses were common in the area of insurance for the elderly. One of the worst problems was the misuse of these terms. All sorts of strange products were called Medicare supplements. To address this problem, model legislation was suggested by Congress in 1980 and in the same year, Maryland enacted its own Medicare Supplement Act. This act defines MediGap policies and sets standards which must be met, in order for a policy to be so called.

Did Maryland's Medicare Supplement Act affect availability for such policies?

Yes. For various reasons, a number of insurers have withdrawn from this market rather than meet the required standards.

Is a supplement to Medicare necessary?

Since Medicare covers less than half of the total medical expense incurred by its recipients, it would appear that some sort of supplement is needed to take care of this balance. If the gap is not met in some way, such as through insurance, membership in a health maintenance organization, or medical assistance for the very needed, it must be paid out of the citizen's own resources.

How can Medicare supplement policies be improved?

This is a difficult question. If the State were to mandate even higher benefits and standards, it seems probable that there might be even more shrinkage of the insurance market. However, even if this didn't occur, it seems inevitable that the premium costs would go even higher. By way of illustration, Blue Cross/Blue Shield of Maryland introduced its high option nongroup Medicare supplement in 1981 at an annual rate of $393. Today that program's annual cost is $1,126. I didn't figure out what the percentage was.

Are there many people unable to afford Medicare supplement insurance, and what effect does that lack of insurance have on them?

According to studies made by the Congressional Budget Office, as reported in the Baltimore Morning Sun on March 27, 1986, 20 percent of Medicare recipients "had no protection other than Medicare against health care costs." This group numbers about 5.5 million. CBO estimates that elderly people without supplemental insurance will pay an average of $710 from their own funds for medical and hospital care in 1987, while Medicare beneficiaries also enrolled in private plans will pay $940.

The conclusion to be drawn from these figures is inevitable. Lack of insurance to support Medicare restricts one's access to medical care. Further, it seems reasonable to conclude that if the cost of health care continues to increase at its present rates—9.3 percent in the Baltimore area for 1985—this disparity between the haves and the have nots will increase even further.

Finally, it also seems possible that the numbers of have nots will increase, due to inability to afford private insurance.

That is my prepared remarks, Congresswoman, I welcome any questions that you would have.

Mrs. BENTLEY. We will ask questions of the whole panel at the end.

Mr. La Asmar.

STATEMENT OF JOSEPH LA ASMAR

Mr. LA ASMAR. Yes, Mrs. Bentley, if it is permissible, I am going to have my marketing manager read the testimony. I have a little bit of a sore throat.

Mrs. BENTLEY. Glad to have him.

Mr. BAKER. Thank you, Congresswoman.

The Chesapeake Health Plan is pleased to be giving testimony to the field hearing on the subject of health maintenance organizations as a means of controlling health care expenses for the elderly.

Health maintenance organizations, one of the industries that is changing our definition of health care in this country, is experiencing explosive growth. Nationwide there are now over 525 registered HMO's, where just over 2 years ago there were less than 200 operative. Why the rapid growth? I will discuss the reasons for this and focus on the Cheaspeake Health Plan, a Maryland health maintenance organization, or HMO, where I am marketing manager.

HMO's such as Chesapeake Health Plan, provide comprehensive health care to enrolled members on a prepaid basis. This means that for a set monthly premium, all of your care is provided for you through a provider of the HMO. HMO's you see, are different from most traditional health care insurers, in the fact that they provide the medical care as well as the insurance program.

HMO's are generally able to offer greater health care value to the public. Chesapeake Health Plan, for example, provides all inpatient hospital care, including medical and surgical physician services, diagnostic services, inpatient specialist care, and lab services.

At Chesapeake Health Plan, out of hospital care is also offered on a prepaid basis. Routine office visits, urgent and emergency care, specialist care, home health visits, and prescription drugs are provided without any out-of-pocket health care costs. These out-of-pocket health care costs, referred to commonly as copayments, are charges required at time of service for certain benefits. While most HMO's provide the same level of benefits, the degree of copayments may vary from HMO to HMO.

At Chesapeake Health Plan, there are no copayments so our members are better able to budget their personal finances, not having to worry about unexpected medical costs.

HMO's differ from traditional health insurance in several important ways in addition to what I have just mentioned. As you all know, traditional insurance hospital benefits usually have a first dollar deductible that you as a member are required to pay. Then a dollar amount of services is usually available to you for care after the deductible is satisfied. With this amount, usually the plan pays some percentage of the bill and you as the member will be responsible for the balance.

With HMO's like Chesapeake Health Plan, your inpatient care is paid first dollar and last dollar. The prepaid HMO concept of health care also eliminates the need for making a claim and waiting for reimbursement. All medical service charges are sent directly to the HMO. As a member you never see a bill for covered services. This is a pleasant change for many people who are used to the cumbersome claim systems many indemnity insurance plans use.

For all the benefits and services offered by an HMO, like Chesapeake Health Plan, there are some points about how the HMO plan delivers care that should be pointed out.

HMO's provide care through a system of medical centers, physicians, and specialists. This is a limited network. By this I mean that unlike traditional indemnity insurance, where you as a member of the indemnity plan, could go to virtually any physician for your care, HMO members can only go to HMO centers, or approved primary care physicians and specialists.

It should be said that this directed system of health care may not be appealing to everyone. For example, people who have longstanding physician relationships may not wish to stop seeing their physician, even though a HMO may offer much more in the way of paid in full benefits and services. This is a question that should be weighed heavily when considering a HMO. You will initially see an unfamiliar physician when you join the HMO. Soon, however, that physician will earn your confidence.

Additionally, HMO's should only be considered if HMO centers and services are close to the member and easily accessible. An HMO should not be considered if, for example, health care facilities are located more than 20 minutes away in drive time.

What does the future hold for HMO's? The future is very bright as industry experts predict that the HMO industry will capture 45 percent of the entire national health insurance market by 1995. The health insurance market has caught the vision that managed health care is the way to keep medical care efficient, while eliminating waste and abuse, that costs us all extra unnecessary expense.

In closing, business and industry have realized that HMO's are an important ally in keeping the cost of health care in check. They have welcomed the preventive care that HMO's have been putting into practice for years. This same attractiveness is evident in the health care market to the elderly. Many of our seniors see the real advantages of prepaid health care in maintaining their good health. HMO's are particularly attractive to the many citizens who are on fixed incomes, and cannot afford the havoc that traditional insurance plans can have on the budget. As an industry, HMO's are continuing to look for ways to educate the population on the advantages it offers, working with organizations like AARP, for example.

HMO's represent a history of value in health care and a future of promise for individuals currently in the non-health-maintenance organization sector of the health care market.

Thank you.

Mrs. Bentley. Thank you, Mr. Richmond.

You mentioned that the elderly people without supplemental insurance will pay an average of $710 from their own funds for medical and hospital care in 1978, while health care beneficiaries also enrolled in private plans will pay $940. That would appear to me it would be more of an advantage not to have any supplementary insurance. You are saving about $230, am I right or wrong?

Mr. Richmond. I wish I had brought the clippings. I may have reversed the figures.

Mrs. Bentley. If you think there is a chance that you have, we will leave the record open and you can correct it later.

[The following material was subsequently received from Mr. Richmond:]

[From the Baltimore Morning Sun, Mar. 27, 1986]

CBO Says Medicare Recipients in 1987 Will Pay Average $700 of Own Money

Washington.—The 28 million elderly Americans receiving Medicare benefits will have to pay an average of $700 from their own pockets next year for medical care, the Congressional Budget Office estimated yesterday.

Most beneficiaries have private insurance to help pay for Medicare's deductible and co-insurance charges.

But 20 percent of the elderly, those who are not eligible for complete coverage, must pay these expenses themselves, Nancy M. Gordon, a CBO economist, told the House Energy and Commerce health subcommittee.

In 1984, 5.5 million people, many with low incomes, "had no protection other than Medicare against health care cost," she testified. "The elderly with lower incomes and with greater health care needs were most likely to lack supplementary insurance."

Nearly 30 percent of elderly people with family incomes of under $9,000 were not covered by private insurance to supplement their Medicare benefits in 1984, she said.

The CBO estimated that elderly people without supplemental insurance will pay an average of $710 for medical and hospital care in 1987, while beneficiaires also enrolled in private plans will pay $940, she said.

For those who don't need hospitalization, Medicare beneficiaries without other insurance will pay an average of $650, she said. The average for those also enrolled in other plans will be $950.

People with supplementary coverage will pay more because "those who must actually pay cost-sharing are discouraged from obtaining as much health care as consumed by those who have insurance coverage that 'fills in' their deductible and co-insurance liabilities," Ms. Gordon said.

"The lower use of health care services by the elderly who do not have supplementary coverage . . . occurs despite the fact that these beneficiaries are older and sicker."

Medicare charges hospital patients a $492 deductible for the first day of each stay. The CBO estimated that charge would rise to $572 next year. The supplemental premium for doctors' care outside the hospital is expected to rise from $186 to $217 next year, Ms. Gordon said.

In addition, Medicare patients will have to pay 20 percent of a doctor's bill—about $75—plus any amount in excess of the program's approved fee.

Ms. Gordon said that while the official poverty rate among the elderly dropped from 25.3 percent in 1969 to 12.4 percent two years ago, "a large share of elderly had incomes just above the poverty line."

Mr. **BAKER**. Yes. This was a published report that the Congressional Budget Office had made and the point that they were making was that—perhaps the figures aren't reversed—the point that we were making was that people who do not have private insurance just plain don't go to the doctor as much.

Mrs. **BENTLEY**. They suffer longer, they don't have the preventive maintenance?

Mr. **BAKER**. Yes, right. In other words, that was the point of the article that they probably didn't have insurance because they didn't have money to pay the premiums, which is certainly conceivable, and the point also was that because they didn't have the money to pay. Medicare beneificiaries also enrolled in private plans are going to pay $940 of their resources and insurance being a resource.

Mrs. **BENTLEY**. I see.

You also mentioned that the mounting cost of the nongroup Medicare supplements has risen from $393 in 1981 to $1,126 today. That is about nearly fourfold.

Mr. **BAKER**. That is right. That was just a for instance. It wasn't to pick on the Blues. This is indicative of increases throughout the insurance marketplace.

Mrs. **BENTLEY**. All kinds of medical insurance?

Mr. **BAKER**. Yes.

Mrs. **BENTLEY**. Since you are in the insurance division of the State, what kind of complaints have you received, if any, or have you seen, if any, on the time taken or the time elapsed to pay claims, Blue Shield/Blue Cross, any of the insurance plans, if they pay directly to the patients, have you had evidence of taking too long to pay?

Mr. **RICHMOND**. I think that the Blues, when you asked that question, really suffer by comparison because, their problems have been widely publicized and they are now admitted by their management, and they are promising to straighten out, but certainly they have been guilty of delays.

Of course, what is most unfortunate is that the Blues have also administered Medicare and if Medicare was slow, and then one's Medicare supplemental is also slow, then the result has been that it is a double-whammy and the person is waiting an inordinate length of time to be paid.

As far as the commercial carriers are concerned, the length of time to pay claims overall is not a particular problem.

Mrs. **BENTLEY**. So that most of your complaints have been with the Blues?

Mr. **BAKER**. Yes, in the past 2 years.

Mrs. **BENTLEY**. Have they improved any in the last 3 or 4 months?

Mr. **BAKER**. Yes; they have.

Mrs. **BENTLEY**. Now, do you plan, like the Chesapeake Health Plan, there is no interface, direct interface from your insurance group to the patient. You pay the doctors and the hospital and any outside provider of health care directly?

Mr. **BAKER**. That is correct.

Mrs. **BENTLEY**. So all you have is the patient who buys your service?

Mr. Baker. Yes.

Mrs. Bentley. Then that is it. They don't have to worry about reimbursement or anything else. That is it, with their monthly fee?

Mr. Baker. That is correct. It is a prepaid program. Simply, the premium is paid and all of the billings for medical services are directed to the plan or mailed to the plan. There is no financial interaction with the patients as far as that is concerned. There is no financial interaction with the patient. The prepaid program provides for medical billing directly to the plan. There is no waiting for reimbursement or paying a bill ahead of time to meet the requirements of the invoice and then waiting for your monies to come back to the member.

Mrs. Bentley. You made a statement that even though the patient may not know their physician when they first sign up, they will learn to have confidence in the physician in a short while. Now, one of the criticisms of the HMO, which was given this morning—I don't know if you were here or not—was that there isn't any continuity between the patient and the physician in Medicare. Have you found that to be true?

Mr. La Asmar. That may be possibly true in some HMO's. At ours that is not the case. The primary physician is responsible for all the care of a specific patient that he either selects him or her, or the hospital assigned to them if they choose not to select a physician. That physician has at his command a whole team of people, including social service people, physician specialists, whatever, the pharmacist, the integration of the entire system, so that what we really have is a team that is applying their skills through the efforts of the physician as head of the team.

So that there is no switching unless of course, a patient walks in when that physician is not there. He is not there 24 hours a day, 7 days a week within the appointed system if they show up for their appointments with the same physician.

Mrs. Bentley. How many physicians do you have in your HMO?

Mr. La Asmar. I would say we are an IPA model that means that we have open panel, some closed panel groups also. We have somewhere in the neighborhood I guess of, in Annapolis area some 60 physicians, 65 physicians in the Baltimore area, probably somewhere in the neighorhood of 150 to 200 physicians.

Mrs. Bentley. Do you have much of a turnover among your physicians, or do those who join usually stay in as a member, or how does that work?

Mr. La Asmar. We have very little or low turnover with our physicians, but that is again a matter, of course, of the way that we have to deal with our physicians. Our purpose in signing a physician is a long-term relationship and the physician knows that and we know that, so in doing the contractual effort to bring them on board with us, we look for people who are well regarded by their peers, not just by the patients, but by their peers. We bring people on who are board certified and have eligible credentials that would make us comfortable with their practice. They at least have to be people who meet the standards of practice in the community. Having gone through a selection and evaluation process, we find that we have less than 3-percent turnover in our physicians.

Mrs. **Bentley**. Have you made any comparative cost studies as to how much it would cost a family or a senior citizen and his spouse to use your services versus going into the outside?

Mr. **La Asmar**. To the indemnity program?

Mrs. **Bentley**. Yes.

Mr. **La Asmar**. It is interesting that Mr. Richmond's numbers are quite within the realm of reality. The average, or at least with us, the cost for a person over 65, is above their part A and part B coverage. The wraparound that we provide is about $56 to $61, depending on the add-ons.

Mrs. **Bentley**. Per month?

Mr. **La Asmar**. Per month. So it is really in the neighborhood of $700 to $750 per year. But that is the total. There is no additional out-of-pocket health care costs.

Mrs. **Bentley**. Does that include medicine?

Mr. **La Asmar**. Yes, it does. it includes everything. That is interesting, because when you look at a TEFRA cost, Mr. Richmond proposed, was resulting from the deferring of health care, deferring the obtaining of health care. That really is not a reduction in cost, it is a reduction in the cost to the individual's out-of-pocket health care costs. But in the overall scheme of cost of health care delivery, that is usually increased cost because intervention occurs later in the progress of the disease or illness. So that the part A costs are going to be significantly higher.

For instance, the hospitalization costs, and that really has to be looked at as part of the macrosystem and not as the out-of-pocket health care costs to the individual patient.

Mrs. **Bentley**. Mr. Blaz.

Mr. **Blaz**. Thank you.

To set the stage for the question I am about to ask, in my community, in my district, HMO is very popular. I think the thing to do is to be a member of HMO, and yet this morning I heard testimony that was not very complimentary or flattering to some extent to the HMO's. How does one in your business counter the allegations that are thrown your way: that this is a profitmaking, which obviously it has to be to survive to some degree, and such things as, you are not interested in anything but the profit, and that you don't offer anything for nothing, which is also understandable.

I got the feeling this morning that there might be some people that do not look upon your services as something to belong to, yet in my community it is the thing to do. What can you say to enlighten me?

Mr. **La Asmar**. Congressman Blaz, I think there are people for whom HMO's are an option, that is, in their best interest, and then there are those for whom it is not. If a person likes to shop for health care, or wants to feel like they need two or three opinions from varying sources on an illness, or they prefer to check on the physician by going to another physician for the same illness—we do advocate second opinions, I am not saying we don't—somebody who is a shopper in the health care system, HMO services aren't for them, and there are those people who like to have that advantage.

There are also those people who did not like the confinements, if you would, of going to a specific system, they like the freedom of going where they wish when they wish. If it happens to be that they want to go to someone near their office that is not participating with the HMO's, they would like that available. Again, that is not for everyone.

As to the statement that you made about whether or not HMO's are in it for profit or in it simply for the dollar, I would wager that if one looked at all the countless testimony and history of HMO's that has been delivered before Congress, this State in its legislature, and its administration, that you would find that dollar for dollar HMO's deliver more services per dollar than their indemnity counterpart simply because the system eliminates many of the intersteps between the insurance mechanism and delivery mechanism.

I am not saying that is always going to be the case with all HMO's. I can tell you that when we look at what someone receives within our system, we know that they are getting more for their dollar than they would if they purchased those services on the outside.

As an example, I can sit here and tell you quite straightforwardly, that we negotiate with physicians. Like specialists, for instance, if you went to see a cardiologist outside of our system and he were charging you let's say $40 for the office visit. For a specialty visit we have negotiated a contract with him in which he reimburses somewhere between 70 and 80 percent of his standard office fees. Office fees are not covered as well now for anybody in any indemnity carrier system unless you do it through major medical at the end of the year, or whenever you gather your expense.

In our system we have already procured it at a lesser cost and there is no gimmick to that, we simply are directing services to the individual. He no longer has to bill and collect, there is no billing and no collection, so we can afford to do it more cheaply. It is more direct with us, and a better buy for our patients.

So that is the advantage of the system. We can provide a service for a lesser cost.

Mr. BLAZ. It does strike me as kind of unusual. I don't own stock in any of these but it does strike me unusual in my community, which is not a rich community, I come from very—per capita income is much lower than most communities in the States—but they view the HMO's as—let me put it this way—it strikes me as odd some people would pay heavily for insurance for 4-wheel-drive vehicles without any hesitation whatsoever, 2-wheel-drive person, he would explain that they can't afford to do that and it strikes me odd one would put his own health beneath that of his 4-wheel drive.

Let me ask you a question that maybe is a little bit more difficult than the apparently complimentary remarks I have about HMO's. That is, do you have any solution for the indigents, the people who just don't have the wherewithal to afford anything whatsoever? I have a sister who works at a hospital and one of her laments in life is coming home every night and saying I just couldn't bear to see those people coming in and not being able to be given the proper care because they don't own anything.

Might you have a pearl of wisdom you want to share through this aging Congressman, how we might solve the problems of the indigent?

Mr. **La Asmar**. We share the aging together. I think there is a societal need to provide care for those people who are caught in between different systems and different delivery mechanisms. Without a doubt, in places like Baltimore where we are changing from a heavy industrial market to a service market, and we are retraining and reorientating, there are going to be those who run out of health insurance and who do not qualify for public assistance.

I think that in some respects it is a problem of society as a whole. In other respects, it is part of the medical delivery system within the State, to begin to deal with it. We have dealt with it in providing sliding fee scale services to people who could not afford it. We provide the service and sliding fee scale, and we only have to do that to a certain degree. We can't do that for everyone that comes to the door so to speak.

Over the last several years we have sought and received section 330, Public Health Service money to aid us in providing primary care to people who are between public assistance and an ability to sustain their health care on an ongoing basis. But I think that nationally, as well as locally, the problem has to be addressed, because this is a so-called gray area. It is getting larger, especially in the cities. We see it here.

I don't have a sure fire solution. I know we have worked with with the city, Baltimore County, the steelworkers, and others, to try to bring the various social elements together. That is a private area response, I am not sure it is as adequate as a system of delivery.

Mr. **Blaz**. Mr. Richmond, could you make a comment on that rather difficult question on how to solve the problems of our indigent?

Mr. **Richmond**. To solve that problem would take the wisdom of Solomon. Only I concur with the gentleman's remarks. The only short term solution that I see is that medical assistance, I believe, should be made more liberal and somewhat more accessible, rather than less liberal, as it has become in more recent years. In the long range, my personal view is that revolutionary changes will have to be required in our health care system and I don't think you want me to go into that. For the short term, to address people's needs right now, I just think that medical assistance is doing a terrible job. It is available to those who are completely destitute. If you have got a welfare card you automatically get medical assistance. If you have the slightest bit in the way of assets, then you are too rich for Medicare. You may be eating macaroni and you may be eating canned beans at the end of the month before your next check comes due and yet you are regarded as too affluent. To me, I feel that is a disgrace.

Mr. **Blaz**. Thank you very much.

Mrs. **Bentley**. Let me ask you one other question, Mr. La Asmar, if you have members, let's say a couple in their seventies, and one of them develops a terminal illness which is prolonged for 2 or 3 years, and requires a great deal of hospitalization, they cannot afford to pay the $51 a month to you once this illness occurs, what happens to those? Do you throw them out as members, do you take care of them, what happens?

Mr. **La Asmar**. I think this is a multifaceted question. If you are looking at someone who's incident of illness began when they could afford to pay for it, we have a responsibility both morally and ethically to continue their care.

Mrs. **Bentley**. Do you do it?

Mr. **La Asmar**. Yes. If you are talking about someone who has a short-term duration illness, I am not certain that we could do it if it was something that was a couple of months, they were back out of the hospital and then a new episode of illness occurred. I think it is fair to say that you have to have the revenue from the premium to continue the care. But on an episode of illness that is prolonged, without a doubt, that person's care would be continued and provided for.

Mrs. **Bentley**. I think there is a great fear among the elderly in particular, and actually among any family, about the high cost of catastrophic health care, what is it going to do to the resources of that family. I think that this is a valid fear.

I also think from the point of view of comprehensive systems of care such as HMO's, and other systems that we either are seeing or will see in the future, that the answer perhaps is that within that system. The application of the methodologies of health care such as evaluating the person for their ability to return to the home and perform normal, routine, daily functions, has a great deal to do with how you control the cost of health care, and with controlling the in-patient cost this is the high dollar cost. One releases dollars for coordinated home health care, visiting nurse service, homemaker's service, and other things that are a benefit to have for a person, especially for an elderly person, putting them into the home and helping them stay there.

I went through an episode which ended just a year ago. My father, who was suffering from congenital heart disease, over the past 5 years, by coordinating with the hospital and other services, was able to stay at home where it was a lot more comfortable and except for small periods of time where he had to be hospitalized, he could be cared for by visiting nurses and my mother.

So I think that there is a certain dignity that one needs to preserve and if one can do that in the family surrounding, then I think it is better. I am an advocate of this. It can be done for less dollars with more application of direct care than if one imposes high technology in a hospital where high technology isn't always needed. It is the human aspect that is needed.

Our next witness is Mr. Gary Eng from the Blue Cross/Blue Shield of Maryland. Blue Cross, of course, is one agency that has been on the hot spot for some time, so Mr. Eng, it is all yours.

STATEMENT OF GARY L. ENG, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF MARYLAND

Mr. **Eng**. Thank you very much.

I am Gary Eng, I am a senior vice president of Blue Cross. My concern at Blue Cross is senior health care programs. I appreciate the opportunity to meet with you today to share with you our observations on the current situation, our concerns about it, and our recommendations.

Blue Cross of Maryland, a nonprofit corporation, is a familiar and trusted name to the citizens of Maryland. Our corporate purpose, simply stated, is to promote the delivery of the quality health care at the lowest possible cost. Interwoven with this basic purpose is a strong commitment to service and to the community we serve. We have 50 years of experience in meeting this commitment.

This experience has earned us a reputation as a leader in health care insurance, both on a local and national level. As the largest private health care insurer in Maryland, we cover over 1.6 million members. Last year alone, we processed some 17 million claims, and paid $1.7 billion in benefits.

But we are not a mere payor of claims. We achieved our reputation through innovative and responsive approaches to the challenges presented by the complex health care industry. Today, these challenges center on finding the delicate balance between delivering quality health care and financing that care.

In line with this corporate purpose, and prompted by the initiative taken by the Federal Government, we began to analyze the Federal Medicare Program. For 20 years, we have been the Medicare contractor in Maryland, administering both part A and part B for our State's beneficiaries. We know the program has made great strides in advancing the health and well being of our senior citizens. However, we are also aware that this vital program has problems. These problems must be attended to if Medicare is to continue as a viable health care insurance program for seniors.

The first major problem is cost. In fiscal year 1967, the first year of operation, Medicare cost the Federal Government $3.2 billion. For fiscal year 1985, the cost had exploded to over $70 billion. This figure is more alarming when one considers that there has been no corresponding increase in coverage. Medicare has not expanded benefits. It has added new categories of patients, but this and the growing senior population does not account for the astronomical rise in cost.

It is ironic that the very segment of the population Medicare has designed to protect is the most adversely affected by cost. Seniors today are paying 15 percent of their income on health care costs, the same percentage they bore before the Medicare Program was enacted. Within 4 years, it is estimated that seniors will be using nearly 19 percent of their income to help cover their health care costs.

These figures are understandable when one considers the increases in deductibles and coinsurance provisions of Medicare. In 1967, the first day in the hospital cost a beneficiary $40; this was the inpatient deductible required by the program. Today, beneficiaries must pay $492 for that first day of inpatient care, an 1,130 percent increase over the original part A deductible. The Congressional Budget Office reports that the part A deductible will increase to $572 in 1987.

Another dimension to the Medicare dilemma is service. Seniors expect and deserve prompt, courteous service. They also should be divorced from the redtape and and bureaucracy which surrounds the highly complex and confusing program. As a contractor, we have been delivering service according to Federal standards. We are proud of our current ranking as ninth best part B carrier in the Nation. But we know beneficiaries and providers are not satisfied with this level of service. Neither are we. Something must be done to address the realistic service expectations of those who use the Medicare Program.

Medicare is also affected by recent legislation to balance the Federal budget. The Gramm-Rudman-Hollings bill seeks to save money through certain reductions. The law permits a 1-percent reduction in payments in 1986 and up to 2 percent in each of the next 4 years. Beneficiaries and providers now are receiving benefit payments reduced by this 1 percent. Also, administrative budgets may be reduced by 4.3 percent. The result may lead to a further erosion in service as evidenced by the lowering of Government standards for claims processing. Less claims will be processed within 30 days causing greater concern on the part of beneficiaries and providers alike.

As a health insurer committed to the senior community and concerned about the deterioration of the Medicare Program, we understood a series of activities from which we hoped to ascertain the health concerns and needs of the senior. We have conducted focus groups, surveys and met with over 100 senior groups. The results are clear. Senior are interested and concerned about their health care coverage. They are worried about the future of Medicare and their own ability to protect themselves against health care costs. They want simple, easy to understand explanations about their coverages. They want good service on their claims. Over 12,000 seniors have voiced their opinions that they want a choice in their health care protection.

The current HMO/CMP medicare risk contract approach is one initiative that addresses some of the problems in the Medicare Program. The effectiveness of this initiative is untested both from the financial and beneficiary satisfaction viewpoint. Depending on the enrollment bias, the TEFRA medicare risk contracts potentially could cost HCFA more money to administer the program than in the absence of the initiative, only exacerbating the current financial problems within the medicare program. In addition, given the limited enrollment capacity of health maintenance organizations, the majority of the Medicare beneficiaries will remain unaffected by the initiative.

Is it possible to create a program that presents a balanced, equitable answer to the crisis developing within Medicare? We believe the answer is yes, and that a workable solution is within a proposal we have submitted to the Federal Government.

Our proposal, the medicare demonstration project, seeks to incorporate private business concepts and practices into a Federal program. We want to emphasize that it is imperative that the Federal Government remain responsible for Medicare. Basically, our proposal calls for Blue Cross of Maryland to share the risk of the Medicare Program with the Federal Government and simultaneously offer beneficiaries a choice among alternate forms of coverage.

In developing the proposal, we wanted to test several key concepts which, if successful, would help alleviate the problems of the Medicare environment. The first concept is beneficiary choice. We wanted to determine whether or not seniors will select coverages with better or different benefits than available under Medicare.

Another concept to be studied by the proposal is competition among alternate coverage programs. The question: Can the economic forces at work in the private sector provide an array of comprehensive coverages for the senior population at a reasonable cost?

Can alternative health care systems, such as HMO's, and PPO's, deliver cost-effective care to seniors? This involves the use of managed care programs that produce savings in the private sector. Our proposal will help determine the effectiveness of these systems for the senior population.

Also, geographic capitation, an important new element in financing health care, will be tested by the demonstration. The fundamental question here is can the Federal Government, under a fixed rate arrangement, become an efficient purchaser of health insurance rather than a provider of health insurance?

This is the context in which we designed and developed the Medicare demonstration project. The resulting 300-page proposal represents a practical and workable solution, which not only will resolve the issues, but also will benefit all parties involved with the Medicare Program.

A review of the key elements will attest to the uniqueness of the project:

The first major factor is that Medicare remains unchanged. The Medicare Program will be the same in Maryland as in any other State. Eligibility, benefits, and regulations will be the sole responsibility of the Federal Government.

And there is no risk for the beneficiaries. Our liberal enrollment regulations eliminate the risk of trying a new program. If seniors choose another coverage option in lieu of Medicare and find it not to their liking, they may return to Medicare or select another option. Medicare will always be available to beneficiaries.

Under the demonstration, we plan to offer six options to some 300,000 Maryland beneficiaries. These options will range from basic Medicare to a comprehensive Blue Cross Program. Two of the options are supplemental coverages to Medicare, similar to products currently available in the marketplace. The three remaining options, called private coverage alternatives, include an HMO and two statewide provider network programs. These options will provide coverage that far exceeds Medicare's and includes benefits for prescription drugs, 365 days of paid-in-full hospitalization and no balance billing when network physicians are used. This array of options gives beneficiaries across the State the opportunity to improve their coverage.

Another key point is the utilization of a prospective capitation rate, which will be set by the Federal Government. The Government now will pay a fixed amount to finance Medicare for a large portion of Maryland beneficiaries.

Included in the proposal are managed care concepts, such as utilization review, cost containment, and preventive care that are designed to reduce cost and assure a high quality of care. These programs have been successfully implemented under our private lines of business. In addition to our existing quality assurance programs, we are working with nationally recognized health care authorities to develop a quality assurance program specifically for the project which will promote a logical continuum of care that is absent in today's traditional fee-for-service environment.

One enterprising element of the proposal is the sharing of any underwriting gains with the Federal Government and the beneficiaries. We propose to return 50 percent of any savings we accrue to the Federal Government. We then will return to the beneficiaries half of our savings in the form of benefit enhancements or rate stabilization, after a suitable reserve level is attained. Conversely, any losses will be shared equally with the Federal Government within a risk corridor which provides significant incentives to perform without jeopardizing the solvency of Blue Cross of Maryland.

The Federal Government will reimburse Blue Cross of Maryland 95 percent of the per capita rate for all seniors who select a private coverage alternative. This automatically generates an initial savings to the Federal Government of 5 percent.

And last, the proposal calls for the State, the Federal Government, and seniors to have a say in the operation and implementation of the project. The State insurance commission is empowered by law to oversee the conduct of our business, focusing on areas such as contracts, rates, advertising, reserve levels, and service. HCFA will retain the responsibility for Medicare and also will appoint an independent evaluator to assess all aspects of the project. A project operations committee, composed of representatives from HCFA, the State insurance division, the State department of health and mental hygiene, the State office of the aging, and Blue Cross of Maryland, will oversee the project. Finally, senior advisory councils will be organized statewide to provide direct beneficiary input on benefits, communication and educational programs, policies, and health concerns.

These essential points of the project attest to the thoroughness and care we put into the proposal. Closer scrutiny reveals that part of the uniqueness of the proposal lies in its balanced approach for all parties involved.

In short, the project is based on the principle of fairness. It is fair to beneficiaries, providers, the Federal Government, Blue Cross of Maryland, the State of Maryland, and our competitors.

Maryland's beneficiaries will benefit because, for the first time, they will be free to make a choice in their health care coverage. They also have the opportunity to obtain improved coverage to protect themselves against the rising cost of health care and to expand their existing Medicare benefits. This is made available to them at no risk. And they will experience improved service because Blue Cross of Maryland must remain responsive to the needs of its customers.

For the provider community, the proposal offers patient direction, reduced paperwork, and a fair reimbursement level based on existing Blue Cross payment profiles. It will help to preserve the Medicare waiver through the promotion of cost-effective care. In addition, the proposal offers a choice among all of Maryland's health care delivery systems—HMO, PPO, and traditional fee for service. No one system is promoted over the other.

The Federal Government will benefit through the testing of new concepts which could resolve the impending crisis in Medicare. The demonstration provides the opportunity for the Federal Government to share in the potential savings that may occur from the managed care products.

For the State of Maryland, the project offers the creation of 300 new jobs in a Maryland-based company and adds $145 million to the State's economy over the 5-year period. Also, Maryland would be portrayed as a national leader, a State willing to test new ideas, and a State concerned about its senior population.

And, for Blue Cross of Maryland, it offers an opportunity to help formulate the future direction of Medicare while addressing a recognizable need of a large portion of its membership. In addition, there is the possibility of financial reward. It allows Blue Cross of Maryland to continue its reputation as an innovator and provides the prospect of a successful business venture.

The proposal also benefits our competitors in Maryland. The participation of the large corporation such as Blue Cross of Maryland quickly legitimizes choice and assures massive education of seniors who are then free to choose our programs or those of our competitors. Other health care plans and HMO's which qualify under TEFRA regulations will be allowed to compete with us for the senior market.

We at Blue Cross of Maryland, believe in the Medicare demonstration project, its potential, and its advantages for all sectors involved in the process. With our 50 years of experience in providing health care coverage at the lowest possible cost and our two decades of Medicare administration, we believe that we have designed a program that can work in Maryland for all Marylanders.

[The prepared statement of Mr. Eng follows:]

PREPARED STATEMENT OF GARY L. ENG, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF MARYLAND

Blue Cross and Blue Shield of Maryland, Inc., a non-profit corporation, is the largest private health care insurer in Maryland with over 1.6 million members. The corporation began as two separate and distinct organizations. The Blue Cross Plan was established in 1937 to offer Marylanders protection against the cost of hospitalization. Within a few years, the fledging Blue Cross Plan proved a success, and in 1950 a companion organization, the Blue Shield Plan was launched. Its objectives was to help Marylanders meet the cost of medical-surgical care.

Over the years, the two Plans developed a multitude of new products and programs in response to rapidly growing market demands. They have kept pace with the latest technological innovations and advancements in the highly complex field of health care. They channeled their efforts into the delivery of sound reliable coverage and quality service, at the most reasonable cost. They continue to return on an average more than 90 cents in benefits for every dollar of subscription income. They have worked with providers of health care services to assure members of quality and cost-effective health care and they have actively explored experimental programs which help point the way to better methods of delivery and financing health care services. As a result, more Maryland businesses and individuals have turned to BCBSM for health care protection than any other organization.

In 1984, the two Plans were consolidated officially into one corporation. This represented the culmination of several years of consolidating internal operations to better serve BCBSMD members. The final consolidation has produced a stronger, more efficient and more effective Corporation dedicated to serving the entire Maryland community.

Experience

BCBSMD has nearly 50 years of experience in providing health care protection. This experience has earned the Corporation the reputation as a leader on the Maryland health care scene. Last year alone the Corporation processed some 17 million claims, representing more than $1.7 billion in benefits, under its regular programs and the Medicare program which the Corporation administers for the federal government. These figures attest to the high level of performance demanded of the Corporation.

This experience also is evident in the diverse variety of programs available from BCBSMD. Whether it is responding to the newest advancement in medical science, such as formulating a heart transplant coverage program, or answering an account's need for more cost-sharing products, such as a preferred provider arrangement, the Corporation has acted in a responsive manner. This sensitivity to the health care environment is the result of working closely with all segments of the industry to monitor, evaluate and implement programs that address health care needs while keeping costs reasonable.

Service Orientation

A dedication to quality service is what sets BCBSMD apart from its competition. Much of its success can be traced to the 2,600 people who work for the Corporation. They are Marylanders who work for a Maryland-based organization, and as such, can best understand the needs of the Marylanders who have chosen BCBSMD as their health care insurer. Great emphasis is placed on recruiting, hiring, and educating personnel who are dedicated to providing professional, timely and accurate service to members. Numerous training and development courses are routinely implemented for all levels of employees to ensure that the work force remains committed to the concept of quality service. Attention is also focused on new systems design and development which facilitates the handling of subscriber inquiries.

The Corporation also has six district offices located in populous areas of the State to serve the people of the area. These offices are located in Easton, Salisbury, Annapolis, Hagerstown, Frederick, and Cumberland.

The importance attached to quality service is visible in the many consolidation activities that the Corporation has undertaken. Much time, energy and resources were expended to create a consolidated telephone service unit and concurrent claims processing systems. In addition, special inquiry and dedicated service units were formed to address specific accounts and complex problems.

All these activities combine to enhance the reputation of BCBSM as a company that cares about its members.

Cost Containment

As the largest purchaser of health care in Maryland, the Corporation has a vital interest in cost containment. No other company has done or is doing as much to help Marylanders contain health care costs without sacrificing the quality of care as BCBSMD. Its cost containment efforts span more than two decades and are directed into three basic areas: promoting economy in the health care system, encouraging proper utilization of care, and containing administrative costs.

BCBSM representatives work closely with the Health Services Cost Review Commission, the state agency which approves the rates hospitals charge for their service. They provide a consumer-oriented analysis of proposed hospital budgets and rate applications, and their participation helped hold the increase in hospital costs in Maryland below the national average. Also, staff members are involved with the Maryland Health Resources Planning Commission. This agency helps prevent the investment in duplicative and unnecessary health services and facilities. Working with the health planners BCBSMD personnel review proposals for new or expanded facilities and participate in hearings on these proposals. Together these two state agencies were able to save nearly $71.6 million in health care costs for all Marylanders in 1984.

The Corporation vigorously pursues cost containment through proper utilization of services. New programs introduced in 1984 involved review of hospital admissions for medical necessity, audits of hospital charges, and account specific reporting. In addition, there is a long list of programs designed to encourage lower cost alternatives to inpatient hospital care, the most expensive form of care. Amoung the cost saving programs are HomeCare, Hospice, Same-Day Surgery, Second-Opinion, Outpatient Diagnostic Endorsement, and Hemophilia Therapy programs to name a few.

The third element of the cost containment program is administrative costs. BCBSM concentrates on increasing employee productivity and improving claims processing capabilities. Also, the Corporation relies on its Benefit Review and Third Party Liability programs to assure that the bills paid are the proper responsibility of BCBSMD.

Community Involvement

Another aspect of BCBSMD which sets it apart from other health care companies is its involvement in the community. The Corporation is committed to an active public health awareness campaign which helps the community stay physically fit. This campaign takes the form of several activities which concentrate on improving the lifestyle of Marylanders.

Most notable among these activities is the sponsorship of Health Fairs. For five consecutive years, the Corporation has co-sponsored this week-long program which offers health screenings in 55 communities across the state. Some 100,000 Marylanders each received over $100 worth of free health testing since the beginning of the program.

The Byron-Kaufman Fitness Run is another annual event co-sponsored by the Corporation. Over 1,400 men, women, and children participate in this 10-kilometer run. Proceeds from this event are used to sponsor health clinics conducted by the Fitness Campaign.

Another annual activity, co-sponsored by the Corporation, is geared to the older citizen. The Maryland Senior Olympics gives people 55 years of age and older an opportunity to test their athletic skills and demonstrate that age is no deterrent to physical conditioning.

Educating the public is the purpose behind Tel-Med, a telephone information system co-sponsored with the Medical and Chirurgical Faculty of Maryland. This system provides free information on a vast array of health-related topics. More than 380,000 calls were made to the Tel-Med sites at the four participating hospitals in 1983.

Another program which involves the participation of hospitals is "Let's Talk About The Hospital. This program attempts to ease the anxiety of hospitalized children and improve their chances for early recovery through a series of video-taped programs and related print materials featuring Fred Rogers, the host of the popular PBS television show "Mr. Rogers' Neighborhood". Eighteen Maryland hospitals co-sponsor the program along with BCBSM.

To help train physicians in the use of health education techniques with patients, the Corporation co-sponsors the Center for Health Education along with the state's medical society. The Center is the only one of its kind in the country and has been recognized for its work by the U. S. Department of Health and Human Services.

BCBSMD also disseminates information on health care in the belief that an informed public is better equipped to avoid health hazards. Booklets on subjects such as alcoholism, drug abuse, stress and food and fitness are provided free to the general community. The Corporation supplies more than 55,000 official immunization record booklets free-of-charge for families of newborns across the state.

In addition, the Corporation is bringing the wellness concept into the worksite. More than 15,000 employees have been screened for hypertension in the Worksite High Blood Pressure Control Program. BCBSMD personnel work with area employers to set up their own in-house screening and detection programs to identify employees with high blood pressure and to assist them in seeking proper treatment.

Subsidiaries

A sound financial picture, foresighted management and changing market demands have persuaded BCBSMD to invest in the future through the purchase or creation of subsidiary corporations. The success of these affiliates depends largely on the management skills and support that the parent corporation lends to the operations. We have four subsidiaries - two Health Maintenance Organizations (HMO), Willse and Associates, and Health Management Services.
BCBSMD's interest in HMO development can be traced to the early 1970's when marketing of this alternative health care delivery system began. The resulting network of HMOs eventually evolved into the Free State Health Plan. In 1981, the Corporation purchased the Columbia Medical Plan. Today these two affiliates have shown sizeable growth in enrollment and in the number of delivery sites. Free State, with a membership approaching 43,100, has expanded to 17 delivery sites. The Columbia Medical Plan has added three new sites to serve its 42,500 members. Plans call for several additional sites to handle the anticipated enrollment gains of each of the affiliate HMOs.

Willse and Associates represent the Third Party Administrator contracts in which employer groups have expressed interest. This subsidiary, purchased in 1984, processes claims for over 109,200 members.

The latest affiliate to be established by BCBSMD is Health Management Systems. This company is responsible for the development and marketing of a new identification card that effectively combines the latest laser technology with the imprinting and storage of medical information to produce an identification card with memory. This new product was introduced in May 1985.

Medicare Performance

BCBSMD's performance as a Medicare Part A Contractor has been consistently rated satisfactory with outstanding performance in the area of productivity and electronic media claims input. BCBSMD has maintained one of the highest productivity rates over the past ten years due mainly to their extensive hospital automated claims entry network. BCBSMD also supports the Blue Cross and Blue Shield of Metropolitan DC Part A claims processing with its Medicare A System and EMC network.

The Part B performance also has been consistently rated satisfactory, with the temporary exception of the first half of FY 1984. At that time, BCBSMD experienced processing problems and took immediate steps to correct the problems. The success of these efforts is revealed in the latest government evaluation report. BCBSMD's Part B claims processing operation was ranked as the ninth best in the country for FY1985. The report notes that BCBSMD attained passing or higher scores in all areas of performance while making significant improvements in the areas of claims processing, medical review, quality assurance and unit cost. These improvements reflect improvements that began in 1984 and have continued through 1985.

Mrs. Bentley. Mr. Eng, as you know, there has been some opposition—quite a bit of opposition, in fact, amongst the senior citizens and by some Members of Congress, against Blue Cross taking over the Medicare Demonstration Program that you have suggested. One of the principal reasons is the poor response in recent years that Blue Cross has given to paying the bills, to responding to its clients.

Do you want to address that point?

Mr. Eng. Yes.

It is without a doubt absolutely true that senior citizens are disappointed in the service that they receive under the Medicare Program. It is interesting to note that throughout all of 19——

Mrs. Bentley. I am not talking about the response to the Medicare Program—senior citizens.

Mr. Eng. I will address both private and public.

Without a doubt, there is a point throughout 1985 in the area of service to beneficiaries, under the Medicare Program. We exceeded all the standards, did better than all the standards that the Federal Government set for their contractors.

The fact that people still felt it took too long to process claims we believe reflects the fact that the standards that are set for the Medicare Program are not very high standards; they are certainly not competitive standards in the health insurance industry.

Let me simply summarize on the Medicare side by saying we have done better than the standards and they are not producing.

On the private side, our under 65 programs, our performance did suffer during 1985. The changes that have taken place in the health care environment in products, in benefits, caught us frankly not well prepared. We were also overwhelmed at times with the volume of inquiries and claims that came to us as a result of these new products, and we did not do the kind of job that we had done for the many years we have been in business prior.

We have committed ourselves to a course which we believe will bring us to produce better performance for the public. The results are starting to come in; on the private side we are processing claims much faster, and our service is at a much higher level. So the commitment we have made has been a public one, to the public, and to the regulatory bodies that oversee our performance, and we are coming through on that commitment.

Mrs. Bentley. When you say that some people believe that the claims take too long, is 6 months too long?

Mr. Eng. Absolutely. Thirty days is too long for someone who is waiting for a check.

Mrs. Bentley. Well, I have a lot of complaints in my office that go far beyond 30 days that are active complaints right now.

Mr. Eng. I understand that you do those kinds of incidences, and to the extent that we can, I would like for you to continue to make us aware of those so that we can correct them. Our intention is not to take 6 months in processing claims.

Mrs. Bentley. I think one of the most frustrating things that not only senior citizens but other people who have called Blue Cross in the past year and have been irritated with trying to get a telephone answered. And Mel Jones, in fact, was telling me at lunch that he called Blue Cross/Blue Shield on Friday about 2 o'clock in the afternoon, the phone rang 23 times and nobody responded. He called again today, and it rang 17 times and nobody responded.

I had a call from a lady over the weekend where she had called the Blue Cross and rung and rung and rung and no answer. That is no better than the reports I was getting last year. That disturbs me a great deal.

Mr. **Eng**. I can say without any hesitation that they were not calling our private business numbers. If they called Blue Cross and Blue Shield private business numbers, our performance in this area has improved dramatically. In the last several months, we have gone from waits on the telephone, 180 seconds down to in waits in the 30- or 35-second range.

Our Medicare operation is quite different than that. Under the Medicare operation, we are funded to provide service, according to the standards set forth by Uncle Sam. Now, normally, the service level is not the type you describe. Unfortunately, with unusual and unexplained increases in claim volumes in the last several months, that has simply outstripped our ability to service that responsively.

You are also aware, of course, that the Government, with Gramm-Rudman, is not spending money on improving service, and we are in the process of working with them to understand why the volume has increased, and what we can do to restore service to a more reasonable level. People should not wait for 22 rings of the phone. We agree with that.

Mrs. **Bentley**. What is the private number you said people should call? I would like to know it.

Mr. **Eng**. It is our Blue Cross/Blue Shield under 65 service unit. I will get you the phone number and ask that you do call it and check with it.

Mrs. **Bentley**. It is in the phone book under 65?

Mr. **Eng**. Yes.

Mrs. **Bentley**. Because I know last year I tried on several occasions myself, and I couldn't believe it.

What is the over 65 number?

Mr. **Eng**. The Medicare operation. I can't remember the phone number, but I will be glad to provide that to you.

Mrs. **Bentley**. I really think that something should be done about the telephone. I just think it is abominal, frankly.

Mr. **Eng**. We certainly agree with you.

One of the aspects of this demonstration project that we think is attractive is the opportunities that we can have to improve service work with seniors and provide the kind of service that we believe and they believe they deserve. We believe that the standards that we are setting in our private business, for our under 65 folks, are very fine standards. We would like to see that kind of service provided to senior citizens.

Mrs. **Bentley**. Where does that demonstration project stand today?

Mr. **Eng**. We submitted the proposal to the Health Care Financing Administration back in March 1985. It has been under review, and presently no progress has taken place. NCFA, as you know, has undergone quite a bit of personnel change in the last year or so. There has not been a permanent administrator at HCFA to deal with the proposal.

We hope that once one is confirmed, and put in place, that this will be an agenda item of some priority so it can be addressed.

Mrs. BENTLEY. Why do you think you will be able to give better service under it than you are giving now?

Mr. ENG. The products that we have talked about for the under 65 market that we would like to make available in the over 65 market are not nearly so complex, nearly so redtape and bureaucratic bound. All of the products that we are suggesting in the demonstration projects are products where we have the provider of care under contract to bill us directly, to not involve the senior citizens in the paper process. It is the same process that we have for our 65.

Earlier I heard someone speak in terms of the ease of paperwork and in HMO. We would also include those HMO's in our demonstration projects, the ones that Blue Cross and Blue Shield own, so the advantage that would be realized there would be passed along in terms of ease of dealing with the insurance program.

The bottom line is that private industry has not seen its way quite the way the Federal Government has in terms of the design of their health insurance programs. We know—we think we know—certainly the under 65 endorses that there are better ways to construct insurance programs that give better coverage, produce more understanding, and in fact result in better service to the customer.

Mrs. BENTLEY. How many more people do you expect to take on if you get this demonstration project?

Mr. ENG. We would anticipate at this moment—remembering that we have not yet talked to HCFA in entirety about this project—but we would add probably somewhere in the range of 145 people.

Mrs. BENTLEY. 545?

Mr. ENG. 145 over the duration of the contract.

General BLAZ. Mr. Eng, I think this is an audience participation hearing. You probably will get a lot more questions than I can cover. Let me try to represent maybe one or two of the questions they would ask if they were in a position to ask questions.

Would you describe the six options that are available under the projects so that the potential beneficiaries back here might be able to be enlightened by them?

Mr. ENG. Certainly.

The existing Medicare Program would be one option, no changes to it. Medicare here in Maryland would be the same as every State in the Union. We would continue to offer a high and low supplemental policy or MediGap policy, and that would be the most economic choice for folks who wanted to supplement Medicare.

Medicare beneficiaries could select among three other new options. One is Health Maintenance Organization coverage. Blue Cross and Blue Shield has a network of HMO coverage that is available essentially in the Baltimore metropolitan area.

We would also make available a preferred provider organization contract, whereby about half of the physicians in the State contract with the Blue plan and agree to accept our payment as payment in full for the services, our customer services. That product would be hooked up with a standard Blue Cross hospital contract to cover hospital care.

The final option would be a contract which, by the way, is the most widely held contract by the under 65 citizens in our State. This is a contract where about 90 percent of the physicians contract with the plan and accept our payment and do the billing on behalf of the patients. No balance is due to the patient.

That would also be connected or hooked up with a 365-day Blue Cross hospital contract.

The design of these latter two, the preferred provider product and the last product that we call the participating product, is such that it would have no copayments, no deductibles. When a patient was in the hospital, drug coverage would be available under all of the products that I have talked about. The only copayments involved would be a rather nominal one for prescription drugs. I think it is $4 or $5. And a very nominal fee for office visits of $4 or $5.

So, in a nutshell, those are the products, the products that the under 65 population are currently using in the State.

General BLAZ. In contracting for providers, do you have a mechanism, a criterion, by which you judge whether or not this provider should be selected as contrasted to another, or do we have take-them-as-they-come arrangements?

Mr. ENG. Our first concern, of course, is with geographic coverage. We are looking for a good mix of specialties and primary care physicians throughout all areas of the State, as well as on the institutional side. Of course, we are looking to make sure that hospital care is easily available to senior citizens.

In our HMO coverages, there is much more interest in and selectivity regarding the selection of physicians who are under contract or work for the HMO's. I can't share with you the details of that because I am not aware of them. But yes, indeed, there is quite a bit of interest in the providers who are brought into those plans.

General BLAZ. Thank you.

Mrs. BENTLEY. Thank you, Mr. Eng.

Our next panel will include Barbara Hill, who is president of Johns Hopkins Health Plan; and Dr. Patrick Mattingly, who is president of Wyman Park Health System.

Barbara Hill, who is president of the Johns Hopkins Health Plan, was brought to Johns Hopkins in 1983 to organize the health plan, and by October 1984 she had the first HMO with its first group health plan become commercially available as a full service health maintenance organization with 12 sites. In a little over a year, the plan has grown from 1 site to 15 sites under her direction.

Ms. Hill has worked in Baltimore health care for over 10 years knocking on programs offered by primary care services. Her expertise is in program organizational development marketing administration. She is a graduate, phi beta kappa, from Johns Hopkins.

Welcome.

PANEL FIVE: CONSISTING OF BARBARA B. HILL, PRESIDENT, THE JOHNS HOPKINS HEALTH PLAN: AND PATRICK MATTINGLY, M.D., PRESIDENT, WYMAN PARK HEALTH PLAN

STATEMENT OF BARBARA B. HILL

Ms. Hill. Thank you, Congresswoman.

The number of older persons is continually and dramatically rising. By the year 2000, Maryland's over-65 population will increase by 39 percent. The health care needs of the elderly are well known.

Frequently, they present: Multiple conditions, which require close coordination of care; multiple medications, which require monitoring to avoid duplication or conflicting dosage; chronic conditions—at least 50 percent of the elderly have a chronic illness—which require coordination of medical, nonmedical, and supportive services to prevent the conditions from becoming more serious; and longer hospital stays. The average for those over 65 is 11 days versus 4 days for those under 65.

The elderly also use health services frequently; require a wider variety of medical services; need protection against the cost of catastrophic illness; and tend to misunderstand their current health insurance coverage, thinking it covers more than it actually does, and ending up with unexpected expenses when Medicare does not pay all of the medical bills.

Under the traditional Medicare system, participants pay deductibles and coinsurance for hospital care—currently $492, but projected to rise to $572 in 1987—and doctors' services, and assume responsibility, as well, for a portion—20 percent—of each doctor's bill that is above the Medicare limit. These out-of-pocket expenses are unpredictable and substantial. The elderly pay as much as half of their medical bills each year despite Medicare and other traditional insurance programs.

The Congressional Budget Office estimates that an elderly American's average medical bill totals $4,200—nearly 20 percent of total annual income. During the past 10 years, the total amount that participants paid in copayments alone rose 50 percent faster than their income. For retirees on fixed incomes, these expenses can be overwhelming.

Most Medicare participants buy MediGap insurance policies to help pay for Medicare deductibles and coinsurance charges; however, the elderly, with lower incomes and greater health care needs, are the most likely to lack such supplemental insurance. In response to these medical and financial needs, HMO's offer an alternative approach which ensures quality care and reduced costs for this population.

A health maintenance organization, an HMO, is a prepaid system of health care coverage. It offers participants a full range of medical and hospital services for a fixed monthly premium.

Mrs. Bentley. Let me interrupt you and ask you the same questions I asked one of our previous witnesses.

If a couple, or a person has paid, and pays his HMO on a monthly basis, and he is hit with catastrophic illness, and he cannot pay the monthly premium any more, is he going to be covered under your HMO?

Ms. Hill. That is assuming that there is in fact a supplemental premium that is due, and also depending on the benefit package a senior citizen may choose, there may not be any benefit change at all.

The way it is going to work under this Medicare Program is that the Medicare people are going to pay to the HMO's 90 percent of the amount they figure it will have cost them to pay Medicare bills on a fee-for-service basis, so they bill computer systems and churn out how much they would have paid for average senior citizens if they were paying Medicare bills on fee-for-service basis, and pay us 95 percent of that amount.

We, in turn, then have to provide a benefit package for this. If we can do it for less than 95 percent, any profit that we make we don't keep as profits. We must return that to the senior citizens in terms of benefits. So, if our computation says we do it for 92 percent, we are going to get paid 95 percent, we have to figure out what the 3 percent is equal to and add on benefits that we do not have covered under Medicare. So it could well be there is an option package which senior citizens can pick which doesn't have any additional premium at all.

If one were to make a benefit package that has additional things that Medicare did not cover, then there would be a benefit; and if the person could not continue to pay, it would probably have to drop down to a package where there was no premium.

Does that answer your question?

Mrs. Bentley. Yes.

Ms. Hill. HMO's may be considered an insurance policy against medical bills because almost all medical costs, from the care of a simple cold to the most complicated operation, are covered by the monthly premium. Like regular health insurance, HMO's pay the cost of care when the member is ill. But, unlike standard insurance, HMO's also pay to keep participants healthy, providing coverage for outpatient care and preventive routine examinations. The HMO participant does not need to buy MediGap insurance, because virtually all costs are prepaid, there are no bills, claim forms, or deductibles. HMO participants can, therefore, budget their total health care costs with certainty.

At the time of enrollment, each participant selects a personal primary care physician. This physician manages all of the participant's care, providing routine examinations and testing, coordinating specialty services, and overseeing inpatient services when needed. The HMO maintains the complete medical record so all information on a patient is available in one comprehensive arrangement. This managed care approach provides an ongoing doctor-patient relationship and assures that each member has access to the appropriate care, reduces costly duplication of services, and eliminates unnecessary hospitalization.

Some HMO's operate at one or more centralized locations which they own—group/staff model; some HMO's operate through contractual relationships with individual doctor's offices, IPA; some HMO's, like the Johns Hopkins Health Plan, combine delivery systems by having central locations as well as sites in doctors' offices throughout the community, so that access is as convenient as possible for the participant.

Nearly 50 years of experience and extensive research have already documented the ability of HMO's to deliver high-quality care at costs that are lower than under fee for service. To assure quality of care, most HMO's rely primarily on selecting qualified physicians, requiring continued education, and using peer review. The quality assurance mechanisms that traditional insurance programs have only recently launched—second surgical opinions, pre-admission testing, chart reviews—have been used successfully by HMO's for several years. Studies have found that the quality of care for the general population in HMO's equals or exceeds the quality of care under fee for service.

With the HMO track record of quality care at lower cost, it was natural for HCFA to focus on HMO's as an alternative way of meeting the needs of the elderly when confronted with rising Medicare costs and budget cuts. In 1980, Medicare demonstrations were begun to determine the appropriateness of caring for the elderly in HMO's. The initial findings of quality care, lower costs, and member satisfaction resulted in the Tax Equity and Fiscal Responsibility Act [TEFRA] amendments in 1982 and publication of HCFA regulations in 1985. The regulations encouraged HMO's to establish contractual agreements to enroll medical participants.

HMO's may offer special programs to Medicare enrollees in one of three ways: through supplemental programs, cost contracts, or risk contracts.

One, through supplemental programs, an HMO makes it possible for an employer group to continue full group benefits for its retirees. Each retiree maintains Medicare eligibility and the HMO agrees to provide whatever additional benefits are needed to equal the employer's full group coverage.

Two, a cost contract is a payment arrangement between an HMO and Medicare. The HMO agrees to provide services and Medicare agrees to pay the HMO based on the reasonable cost of covered services. Medicare members pay the HMO a monthly premium to cover Medicare deductibles and coinsurances. The member is not restricted to using the HMO for all medical services.

When the member receives services out of the plan, Medicare pays for the services as if the person were not an HMO member. This payment approach is similar to the traditional fee for service system. Lacking the direct financial incentives which would encourage cost-effective care, such cost contracts are not the usual way that HMO's function.

Three, under a risk contract between an HMO and Medicare, the HMO agrees to provide services based on a predetermined payment amount for the enrollment year. This amount is a percentage of what Medicare projects would have been paid out for services provided under fee for service.

The HMO assumes the calculated risk of providing all needed care at or under this prepaid amount, and the member agrees to receive all care through the HMO managed care system. This risk contract encourages the primary care physician to closely manage each member's treatment and to use inpatient, referral, and diagnostic services judiciously.

The risk contract usually includes a form of shared savings. A portion of the savings is returned to the HMO members in the form of lowered premiums and/or additional benefits not ordinarily covered by Medicare, such as extended hospital days, prescription drugs, eyeglasses, and dental care.

Under the risk contract approach, Medicare/HMO's are able to offer the additional benefits at little or no additional charge because of the savings which result when HMO's keep members healthy through routine physical examinations and early treatment, by assuring the medical necessity of hospitalization, and by avoiding duplication of services.

The Medicare population is responding positively to the lower costs, quality of care, and accessibility of HMO's. Nationwide, there are nearly 17 million people enrolled in HMO's, including nearly 600,000 Medicare members. Last year, enrollment increased 22.4 percent—a rate greater than ever before—and early reports indicate that members—88 to 99 percent—are satisfied or very satisfied.

Recognizing the special needs of the elderly and the competitive forces in today's health care/insurance marketplace, future Medicare/HMO development would require consideration of the following:

One, avoiding cuts in Medicare funding that will necessitate reduction in benefits. Such cutbacks could make it unattractive for HMO's to participate or for members to join;

Two, weighing carefully the current proposals for geographic capitation demonstrations that would permit large insurance carriers to underwrite the entire Medicare Program in a region. Such programs could pose unfair competitive advantages for the carrier, limit choices to Medicare recipients, and adversely affect the processing of payment;

Three, conducting demonstration HMO programs which would permit more than 50-percent Medicare enrollment. Currently, HMO's are limited as to the number of Medicare enrollees they may have; changes on these limits would allow special HMO's to develop which would concentrate their efforts and resources on programs to satisfy the medical and social needs of the elderly;

Four, promoting the development of long-term and supportive care benefits; and

Five, implementing a national system of quality assurance review for Medicare/HMO's.

The elderly are concerned about costs and access to care. Medicare/HMO's have responded by offering a different style of health care, a style that emphasizes wellness, that coordinates and manages the health needs of the members, and that assures quality. As a result, HMO's present an appropriate response to the needs of the elderly. By joining an HMO, Medicare enrollees place themselves in the mainstream of innovative health care.

Do you have any questions?

Mrs. **Bentley**. We will ask questions after Dr. Mattingly has presented his statement.

Dr. Mattingly, who is president of the Wyman Park Health System, I can say to you, I know a number of people who are very concerned about the continuance of Wyman Park. They are very happy with it.

STATEMENT OF PATRICK MATTINGLY, M.D.

Dr. Mattingly. Thank you.

Mrs. Bentley. Proceed.

Dr. Mattingly. Congresswoman Bentley and Congressman Blaz, I would like to introduce myself. I am Patrick Mattingly. I am a physician and president of Wyman Park Health System in Baltimore.

Wyman Park is a Comprehensive Health Program including a hospital, physicians group, and full service medical center, providing managed health care to uniformed services beneficiaries and prepaid HMO patients, as well as the general community.

One of Wyman Park's areas of concentration is health care for the elderly, particularly innovative ambulatory programs in day care, and rehabilitation. About 30 percent of our uniformed services population is over age 65, and our local community has the highest concentration of elderly in Baltimore City, that being the Hamden-Remington area.

I would like to share with you some of our experiences and thoughts about reducing the cost of health care for our older population, particularly out-of-pocket expenses. Ms. Hill has presented to you how health care organizations can reduce Medicare and patient expenses.

HMO's are the major form of managed health care—properly organized, they can offer a personal doctor-patient relationship, reduce duplication of expensive services, and avoid unnecessary services, particularly hospitalization. To make such managed health care plans work successfully under Medicare, a number of measures must be supported, including maintenance of benefit levels and promotion of long-term and supportive-care benefits; elimination of the 50-percent enrollment cap; and avoiding of noncompetitive geographic capitation plans.

I support these proposals, but I believe we should go another step for many elderly by promoting organized health delivery systems to most effectively implement such managed care plans.

What do I mean by an organized delivery system? In such a system, multiple providers and health care resources are tightly linked and managed so that the patient has easy access to an integrated sequence of services—doctors and other professional providers, hospitals, home care, long-term care, medications—all through a common gateway. This saves the patient from the hassle of finding these multiple services, learning how to use them, and often purchasing duplicative, unnecessary or overpriced services out of pocket. In the long run, such a system also saves on the Medicare costs by preventing more expensive care, particularly hospitalization.

Examples of such organized delivery systems would be Wyman Park's Geriatrics and Ambulatory Rehabilitation Services, or the Geriatrics Center at Frances Scott Key Medical Center, another Hopkins system affiliate. Through the Geriatric Center, an elderly patient can receive personal medical care at home or in the office, rehabilitation, counseling or enter an acute care hospital or access a continuum of long-term care through home care, nursing home services, medical day care, and, if needed, chronic hospitalization.

All of these services are case managed for the individual patient by a primary physician and support staff, and payment is coordinated so that the patient does not bear the brunt of sorting out the complexities of Medicare, Medicaid, and other regulations.

If such organized systems are so effective, why don't we see more of them developed? There are several reasons. Thankfully, most elderly people don't need most of these services. While Americans over age 65 as a group do require more health care services, most individuals do not have major chronic illnesses that require complex case management. For most, a managed plan provided under the guidance of an individual physician is an adequate system for both quality and cost containment. But a smaller percentage of elderly patients—perhaps 20 percent—account for the larger percentage—perhaps over 50 percent—of Medicare costs. For these frail elderly, an integrated system can improve care and reduce expense—both to Medicare and to the patient.

Another reason that such systems are not developed is that under present reimbursement they cannot support themselves and must be subsidized either through grants or institutional charity and donations. Several examples of the perverse incentives in present reimbursement might be helpful.

A frail elderly patient at the FSKMC Geriatrics Center must pay out of pocket for prescription drugs, home care, household services or medical day care at the center. These services could keep the chronic illnesses under control, provide rehabilitation, medication monitoring and prevent recurrent episodes of acute deterioration that often require long costly hospitalization. However, she would be able to receive most of these preventive benefits through Medicare and Medicaid support after hospitalization and after she has exhausted out-of-pocket resources.

An elderly man struggling to regain self-sufficiency at home after a stroke can achieve this without lengthy hospitalization or nursing home care through Wyman Park's Ambulatory Rehabilitation Center. This program provides intensive daily medical and rehabilitation services, and if needed medical day care. But he must first get to the center through specially equipped transportation. The availability of such transportation by commercial vehicles is very limited because of the low reimbursement rate, unless the patient pays out of pocket. Also, reimbursement from Medicare and Medicaid does not cover the cost of services provided which he must pay. Unable to attend the rehabilitation center, he may require acute or chronic hospitalization or nursing home care at greater expense to all parties.

Fortunately, in both these examples the services are being provided by subsidization of the organizations. But net cost to the Government and patient could be reduced, and subsidization removed, if the Medicare and Medicaid systems were designed to reimburse appropriately those services which can prevent hospitalization.

The incentives in the current system are backward. What can be done to correct this situation? In general, both payors and providers must work together to reduce unnecessary utilization and prevent more expensive hospital services. This will serve to carry the available Federal and State funds further, and allow coverage of many costs now borne out of pocket by the patient.

As legislators, there are several specific steps I would urge:

One, support those measures that will make managed health plans, such as HMO's, cost effective for the elderly. Several of these measures are detailed in Ms. Hill's presentation.

Two, support reimbursement by Medicare and Medicaid for those services designed to maintain good health, and in the case of the frail elderly maintain a controlled state of chronic illness, thus preventing the need for more expensive hospital care.

Three, finally, provide research and demonstration funds to encourage the development of organized delivery systems. These projects can evaluate and identify the most effective methods to reduce costs for the highest users of services, thus improving quality while reducing overall costs.

There is a final irony in the lack of research in the delivery of care to the elderly. The Federal Government has supported basic research that produced vaccines and treatment for most infectious diseases such as polio or common fatal pneumonias. This same success has in large part contributed to the increased longevity of Americans, and increased numbers of patients with chronic illnesses requiring more expensive care, care more expensive in dollars than the infections which were prevented.

We must continue basic research into all aspects of acute and chronic disease, but if we do not find effective ways to halt the rising costs of health delivery we will not have enough money to fight both battles.

Thank you.

Mrs. BENTLEY. Thank you.

I thank both of you for your well-thought-out statements.

Ms. Hill, you mentioned that currently HMO's are limited as to the number of Medicare enrollees they may have. Why is that? What is that limitation?

Ms. HILL. Fifty percent.

Mrs. BENTLEY. Now, you say the changes on these limits would allow special HMO's to develop?

Ms. HILL. I would like to see HMO's who focus primarily on the elderly developed. I believe that HMO's who specialize in taking care of senior citizens could develop very special health education programs and home care programs dealing with prescription medications and understanding the balance between those and on diet, group activities. That would be really critical for senior citizens, some kind of day programs for elderly who are still able to live independently but need some kind of assistance during the daytime.

It is not possible for any HMO's, which has 10 percent of its enrollees as Medicare recipients, to hire special coordinators specializing in geriatric care. It is not cost effective or possible for them.

On the other hand, if the Johns Hopkins Health Plan could open another HMO system called the Johns Hopkins Senior Health Plan, which could be a special HMO for senior citizens, it could have that focus but it would require a change in this legislation.

Mrs. BENTLEY. Do you have any questions?

General BLAZ. I am very fascinated by the tandem here because they seem to provide a good capsule of what we have been discussing all day.

Let me ask you a question that has nothing to do necessarily with your testimony. The feeling I get of much great concern to our elderly is that area in which they seem to be unable to pay, the same thing that I—you know my feeling about HMO. I come from a community that has a very high prescription of HMO's, but unfortunately they are those who are unable to do that.

While you have very good plans and suggestions here, the fact remains we do have a population that is awful embarrassing to our country being so rich in so many areas and yet too poor in its care of the elderly. There were some horrible examples given this morning.

What suggestions do you have for the immediate or short-term solution of those people who are indigent simply because they show up—"I can't pay for this care. What can you do for me?" Do you have any suggestions on how we might be able to solve this problem for the short range?

Ms. **Hill**. I am glad that you picked up on the way Dr. Mattingly and I fit together here, and obviously we are two pieces of what is now a major health care system, the Johns Hopkins Health System, and our system does have an approach for handling patients who cannot pay, and we are unique in that regard. And I believe Dr. Mattingly would agree with me that we believe the solution to care for those poor is develop other health care systems. Because in a system that—the nature of Johns Hopkins is one where we are virtually an integrated health care system. We do primary care. We do secondary care. We do tertiary care. We do long-term care. We do home health care. In this system we believe we are prepared in order to be a part of our community to have to care for patients who are unable to pay.

So, in the hospital health plan we don't enroll many home only care for most enrolled on prepaid basis, we see fee for service basis on a sliding fee scale, and that fee slide down to zero. So that we ask obviously for income information. But if a patient is unable to pay, we see the patients for whatever it is that patient is able to manage.

Dr. **Mattingly**. I would add maybe several specific comments.

I think long term there needs to be a significant revision in the emphasis of what we reimburse under our Federal and State programs. As I pointed out, the incentives now are to provide the most expensive care, and through both legislation and revisions in the regulations, and the development of managed health care programs, I think over time you can significantly reverse where you are spending the money and spend it more on the front end, to prevent the expensive services and to prevent the out-of-pocket expenses.

I realize that takes time. What can be done on a shorter range, I think even within the regulatory process with the system set up as it is now, we can reverse some of these things very quickly if people sit down and tackle them.

The problems that I described to you are very real. They are not imaginary. They are specific cases. And these types of things make no sense at all, and it would seem to me that with leadership in Congress and some direction to HCFA and to the States with Medicaid, some of these things could be reversed very quickly so that the reimbursement for those services that will prevent hospital stays, will be sufficient to allow these services to be provided without the patients paying out of pocket.

I think there is where the indigent population, particularly the indigent frail elderly population, is so important.

The last point I would point out is that perhaps what we need to do is look at those areas of the country, perhaps particularly metropolitan areas, but not exclusively, where there are large numbers of what I would describe an indigent frail elderly, and sponsor more special projects, such as the Frances Scott Key Geriatric Center, before all of these services can be provided. It is only possible under the present reimbursement system with some subsidy through grants or other sources. But that, even still, is money well spent, because it can be clearly demonstrated even with the early results that that kind of up-front subsidy prevents much larger payouts down the road under the Medicare system.

So I think there are some steps you can take pretty quickly rather than waiting for the next 10 years to reverse this system.

General Blaz. Quite frankly, I am impressed by the fact that we have products of Harvard and Johns Hopkins, in cahoots with two street fighters—that is what we are. Let's face it. We certainly don't represent Harvard or Johns Hopkins, two of the fine institutions. What you represent, and to the streets here, we just might come up with a solution because we do represent that contingency that is deprived quite a bit. And to hear the two of you strange bedfellows, to come here, I find it very encouraging, quite frankly.

I appreciate your testimony and the candor in which you present it.

Thank you.

Mrs. Bentley. Thank you. Thank you for your statements.

We are going to take a 5-minute break before we have our last witness.

[Recess.]

Mrs. Bentley. We will resume with our final panelist, who is Catherine Kilmurray, from the AARP, and her statement is on catastrophic health care insurance for the elderly and HMO's.

STATEMENT OF CATHERINE KILMURRAY, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. Kilmurray. Thank you and good afternoon. I am very grateful to be here.

As you have just mentioned, my name is Catherine Kilmurray from Joppa, MD. I am a member of the American Association of Retired Persons' National Legislative Council, and I am delighted to be here to share the association's views on catastrophic health insurance coverage. My testimony today also covers some of the hopes and concerns AARP has regarding health maintenance organizations.

The American Association of Retired Persons congratulates the committee for considering how best to fashion catastrophic health insurance coverage. The first task is to accurately define "catastrophic expenses." AARP believes that catastrophic health care expenses should refer to all out-of-pocket expenditures for health care related goods and services, including the cost of health insurance premiums, which exceed a given dollar amount. This definition not only reflects reality, it is also consistent with our income tax laws.

The purpose of catastrophic health insurance should be to provide stop-loss protection against these expenses.

Who, among older Americans, actually experiences catastrophic health care expenses?

A 1985 ICF study commissioned by AARP found that households of noninstitutionalized older persons are already heavily burdened by catastrophic expenses. AARP's study estimated that in 1986, the average total out-of-pocket expenses for noninstitutionalized households will be $1,800 annually; for households with an institutionalized older family member, the annual out-of-pocket expense is over $12,000.

The crisis in health care costs is particularly acute for the very old and the near poor. We found that, on average, total out-of-pocket expenses equal nearly 57 percent of household income for those with $10,000 or less annual income. Unmarried women over age 65 are the most vulnerable to catastrophic expenses. They represent the typical medicare beneficiary and are least able to afford the high out-of-pocket costs they experience.

It is clear from our study that catastrophic expenses are already widespread among medicare beneficiaries. Clearly, this situation is incompatible with the goal of a secure retirement, or even the goal of preserving the family structure against unpredictable health expenses.

What is the greatest source of financial risk to beneficiaries today? According to a HCFA analysis of 1980 Medicare data in which out-of-pocket expenses are defined solely in terms of medicare's copayments and deductible, the preponderance of beneficiary liability is associated with part B covered services. AARP's study supports this conclusion. This finding contradicts the widespread notion that catastrophic costs are generated primarily by hospital stays.

In fact, only 23 percent of Medicare beneficiaries are hospitalized in any given year. Liability due to prolonged hospital stay is extremely rare: in 1978; only 0.6 percent of beneficiaries stayed between 61 and 90 days while 0.2 percent stayed longer than 91 days. Otherwise put, only 4 percent of beneficiaries experienced a part A liability exceeding $190 in 1980.

In contrast, 80 percent of beneficiaries use part B services. Total liability for part B averaged $180 per person. Fourteen percent of beneficiaries experienced part B liability of more than $190—three times the rate of similar part A liability. And, as AARP's study found, actual part B liability is much, much greater if all out-of-pocket health expenses are considered.

While we certainly don't wish to discount the part A liability experienced by some beneficiaries, we need to know more about this subgroup before we can design a policy to address their needs. For example, we don't know whether they are dually eligible for medicare and medicaid or have MediGap insurance. Further, we don't know whether the long stay results from multiple admissions within the same benefit period or is continuous.

We also don't know if these stays occur within a non-PPS facility or unit, and we don't know whether these people could be more appropriately cared for in an alternate setting. We know that the greatest hospital costs tend to be generated by persons in their last year of life, but we don't know how their bills are paid after their demise.

Furthermore, AARP is deeply concerned by the increased focus on prolonged hospital stays experienced by a few persons when part A's basic benefit is eroding in value. The first day deductible for 1986 represents a 23-percent increase over 1985 and will increase an additional 16 percent, to $572, in 1987. That is, the deductible will rise 43 percent in 2 years.

In addition, earlier, often premature hospital discharges in response to DRG's are robbing beneficiaries of needed medical care. Medicare recipients are leaving hospitals sooner and entering a no-care zone where postacute care services are inadequate and often not available at all. We need to address this important problem that affects the 23 percent of beneficiaries who are hospitalized annually.

AARP believes that any catastrophic policy must provide true stop-loss against health care expenses. It is also important to design a policy that will respond to the needs and desires of most persons over age 65. All of our surveys show that Medicare beneficiaries want their coverage to be part of the mainstream of health insurance; they don't want a separate and inferior health care financing and delivery system.

Second, older Americans want to retain the insurance principle of Medicare. This means that the risks should be shared as widely as possible and spread out over time, preferably when wage income can best support premium payments. Premiums can and should be supplemented by additional sources of revenue, such as increased taxes on tobacco products.

Third, they are risk averse. Older Americans want their health expenses to be predictable and limited to a manageable amount—that is why the majority of beneficiaries purchase private supplemental insurance policies. If the Government could offer equivalent or better protection for less cost, we would accept a higher Medicare premium. This premium should be no higher than is necessary to finance strengthened benefits and coverage.

We are concerned that private coverage is available at a cost significantly lower than the premium surcharge proposed by Secretary Bowen. It is not clear why the proposed Medicare surcharge is so high when the Federal risk pool is larger than that covered by private insurers offering Medicare supplemental policies.

We strongly recommend action that would, first of all, stem the erosion of the existing part A benefit. AARP would support legislation designed to address some specific problems that have emerged in the Medicare Program. Such legislation should, one, adjust the prospective payment system and the peer review program to improve the quality of care in acute and postacute care facilities; two, improve access to postacute and long-term care services; three, expand consumer involvement and patients' rights; and four, better integrate the activities of Federal agencies responsible for the health care of the elderly.

AARP staff is pleased to be working with the Congress on legislation to improve the quality of care in the Medicare Program. We are hopeful that legislation now in the hopper will become part of law passed in this legislation session.

Next, we urge that priority be given to instituting stop-loss protection for part B covered and uncovered services which represent the greatest burden to the greatest number of Medicare beneficiaries. The greatest need for stop-loss protection today is in expenses for prescription drugs and long-term care.

Under existing law, Medicare beneficiaries have substantial responsibility for the cost of physician services. Beneficiaries must pay the annual part B deductible of $75, plus 20-percent coinsurance on all reasonable, customary, and prevailing physicians' charges. Between 1972 and 1982, incurred coinsurance charges increased by approximately 345 percent. Moreover, beneficiaries are liable for all charge reductions associated with unassigned physicians' claims.

In 1980, aged beneficiary liability resulting from unassigned claims exceeded $1.3 billion, an amount representing 13 percent of total physicians' charges for the elderly that year. By 1984, unassigned claim liability had risen to over $2 billion.

These three charge components—charge reductions associated with unassigned claims, deductible, and coinsurance—together represent variable beneficiary liability for physicians' services. In 1980, such variable liability for the aged amounted to nearly 35 percent of total physicians' charges due. Further, if part B premium payments representing a form of fixed beneficiary liability are combined with variable beneficiary liability for 1980, the net Medicare contribution against total physicians' charges falls to only 45 percent, the aged beneficiary being responsible for the remaining 55 percent of charges due the physician. It is estimated that total beneficiary liability for physicians' charges due under Medicare increased to cover 60 percent in 1983.

The statistics which have been cited above are based on aggregate data and averages; accordingly, they tend to obscure the personal catastrophe suffered by those elderly individuals who experience unusually high out-of-pocket medical costs, that is, those costs resulting from a catastrophic illness, injury, or a chronic condition.

The proposal developed by HHS Secretary Bowen limits the amount of Medicare A and B costsharing liability to which any aged enrollee would be subject. The proposal accomplishes its catastrophic cap through the imposition of an annual surcharge on all Medicare beneficiaries.

For example, in fiscal year 1986, a part B premium surcharge of $203 would cap part B direct payments for covered charges to $200, and would eliminate the part A copayment. But beneficiaries would still be liable for up to $984 in part A deductibles each year.

Beneficiary liability caps could be set at lower or higher levels by simply adjusting the amount of the surcharge.

The Bowen proposal described here has distinct advantages over the catastrophic proposals considered earlier. It distributes Medicare cost-sharing liability among all enrollees, rather than restricting it merely to the sick or injured. With no increase in program outlays, it sets maximum, predictable limits on deductible and coinsurance expenditures.

It also could substantially reduce the need for the purchase of certain MediGap policies by the elderly. Further, it might encourage insurance companies to develop less expensive policies geared toward covering the risk of major expenditures—or catastrophic costs—rather than first dollar coverage of Medicare gaps. And finally, it offers some peace of mind to the elderly individuals concerned about substantial deductible and coinsurance expenditures associated with both parts of Medicare.

Nevertheless, the proposal is not without its limitations. The liability against which aged beneficiaries are protected under this catastrophic plan derives only from Medicare cost-sharing requirements. The proposal does not incorporate protection for other forms of beneficiary liability such as the costs of noncovered goods and services or charges above the Medicare-allowed amounts on unassigned part B claims.

And finally, depending upon the level at which it is set and the extent to which it reduces the need for Medigap policies, the surcharge itself could represent a significant financial burden, especially for poor and near-poor persons age 65 and older.

The costs associated with long-term intermediate and skilled nursing home care represent the most frightening catastrophic health care expense for which older persons are liable. It is not realistic to discuss catastrophic health insurance coverage for the Medicare program without discussing coverage for long-term care.

The greatest deficiency in the present health care system is the lack of a long-term care system encompassing medical, social, and personal care services provided in a variety of community, home-based, noninstitutional settings.

Because of the aging of the population, demand for long-term care services is increasing. Yet, current demand is not even being met. Today, there are an estimated 3.5 million noninstitutionalized persons aged 65 and over who are functionally dependent, and their numbers are increasing by about 100,000 year. Fifty years from now, in 2036, there may be well over 7 million persons in this category. About one out of three of these functionally dependent older persons is homebound or bedridden. A still larger proportion are alone and isolated. Another 1.2 million older persons are in nursing homes, chronic care hospitals, or other institutions.

Risk of institutionalization increases sharply with age; 22.6 percent of those age 85 and older are in institutions. The need for long-term care has catastrophic consequences for individuals and their families. For example, many studies show that half of all nursing home costs are paid directly by residents. Since nursing home costs can typically range between $1,200 to $1,500 a month, residents rapidly become impoverished.

The House Committee on Aging found that almost half of unmarried residents age 75 and over are impoverished within 13 weeks of their entry into the institution, while 75 percent are impoverished within a year. Spouses of institutionalized persons run similar risks of impoverishment. The financial picture for spouses caring for an Alzheimer's victim at home is equally bleak.

This situation represents a failure of public policy and the private market. What is needed is true insurance protection against the catastrophic costs of long-term care.

Unfortunately, there are few options available to older people to acquire long-term care protection. Medicare nursing home protection is strictly limited, both in duration of protection and level of care, as well as in setting. Medicaid, on the other hand, provides a broader long-term care benefit, but requires beneficiaries to "spend down" most of their resources before Medicaid will provide any benefits whatsoever. These public programs fail to protect people from enormous costs.

Similarly, private long-term care insurance with meaningful benefits at a reasonable cost is not widely available. For the future, increased private sector involvement in meeting long-term care needs must be forthcoming. Private insurance companies should be encouraged to add long-term care benefits to existing policies and develop new policies which would specifically address the elderly's long-term care needs. Over the long term, health insurance accounts—similar to tax-deferred IRA's—could be created providing younger persons with an incentive to save for their future long-term care needs.

AARP is very supportive of the HMO concept because it has a proven record of cost containment, and for the most part, of providing high quality care. As more and more retired persons exercise their HMO option, however, AARP is concerned that the Medicare contribution will be ratcheted down and that the quality of care will erode like it has under PPS.

The incentives driving down the quality of care under PPS are also present in HMO's. The association firmly believes that quality of care monitoring and enforcement mechanisms must be developed and implemented in HMO's as soon as possible. Our Nation's basic commitment to quality health care cannot be permitted to fade under the guise of cost containment.

AARP urges that Congress extend the peer review organizations' jurisdiction to include HMO's ambulatory care, and out-patient settings. Only by monitoring and enforcing high standards for quality care in the entire delivery system can we be assured that our commitments to each other—to young and old alike—will be maintained.

AARP is pleased that the administration recognizes that gaps exist in the medicare benefit package. The Bowen catastrophic insurance proposal is a constructive proposal, but it contains several serious drawbacks. It does not offer true stop-loss because it unrealistically defines catastrophic costs solely in terms of Medicare's deductibles and copayments. It also fails to meaningfully address a crucial source of catastrophic losses to older Americans—long-term care.

AARP believes that increased premiums may be necessary to finance improvements where there are offsetting savings to most beneficiaries, but premium increases must only be used to offset for improved coverage. We are also concerned about those near-poor beneficiaries who can't afford to buy supplemental policies. How would they pay a premium surcharge? That problem looms large and must be addressed.

While AARP supports the HMO concept, it is increasingly concerned that there is virtually no monitoring or enforcement of quality of care standards in HMO's. AARP urges Congress to extend PRO jurisdiction to HMO's, ambulatory and outpatient care settings.

Thank you for listening. And, if you have any questions, I will try to answer them.

Mrs. **Bentley**. Thank you for a very well-thought-out and very informative statement.

I am particularly interested in a couple of your comments. One was that if the Government could offer equivalent or better protection for less cost, we would accept a hire Medicare premium.

Ms. **Kilmurray**. Right.

Mrs. **Bentley**. Now, are you saying there wouldn't have been any Blue Cross supplemental or any HMO or anything like that, but that the premium to the Medicare should cover everything?

Ms. **Kilmurray**. Yes; that is what we are saying. It is a very good idea, so people would not have all supplemental policies and this, that and the other which add up to a lot of expense.

Also, this is very confusing to the elderly people. I know some people have bought four or five different MediGap policies, and they all cover the same thing, and only one of them is going to pay off. If one pays off, the others won't. They are throwing their money away. If it is all covered in one premium, it would be much simpler.

This is one of the reasons we like the HMO, because this is one place where you pay everything at one time and you know what it is and everything is covered.

I, myself, personally have changed my insurance to HMO system about 2 years ago, and I found it very satisfactory. Of course, that is because I haven't had any serious illness. Such as if I required a long hospital stay. But right now it is very satisfactory. I think the idea having a primary physician to whom you go and who will count all your medical expenditures, is an excellent one, if this physician is competent at all.

Mrs. **Bentley**. You mentioned that the greatest need for stop-loss protection today is an expense for prescription drugs and long-term care.

Ms. **Kilmurray**. Yes. These are two things which are not covered by Medicare at all. Most of the HMO's do cover these, but HMO's are not universally available. Although they are a little bit more available than they were a few years ago. I am happy to see in Maryland they have a dozen of them now. I think this is all to the good. As long as there are several different ones competing against each other, I feel the coverage they offer will be better.

Mrs. **Bentley**. Competition is also the spice of life.

Ms. **Kilmurray**. I like the HMO. I signed up because we do have opportunities once a year to change it, and we also have the opportunity to, if we don't like the doctor to whom you are assigned, to say I don't get along with him and let me go to someone else.

Mrs. **Bentley**. Do you have any suggestion on the surcharge how we would bear the burden of the surcharge for the poor and near poor persons; how that might work out? Have you given any real thought to that?

Ms. **Kilmurray**. I am afraid I am not able to make any recommendations on that. We feel that there should be something. One of Secretary Bowen's proposals was to start an additional medicare charge to take place starting at age 45. He felt this would be a time when most workers have some of their early expenses out of the way. If they have children that are going to school, they have got even them at least halfway through, he doesn't know whether he is going to do the college people. That was his suggestion, age 45, everyone would start to pay into something for this long-term care thing that would take care of people.

Mrs. **Bentley**. Congressman Blaz.

General **Blaz**. Thank you.

I want to compliment you on your comprehensive statement, all 11 pages of it. You gave a lot of thought, didn't you?

Ms. **Kilmurray**. Well, I had some help. I didn't do it all myself.

AARP has been very concerned with Medicare costs, all medical care costs, I should say. For the last 3 or 4 years, it has been our primary objective. There has been a big staff that has worked on this.

General **Blaz**. Let me follow up on a question asked earlier; that is, you alluded to earlier. That is the question of confusion as to coverage. I take it that indeed, it is quite prevalent among people, the elderly perhaps more particularly, that when they look at various programs, they are not quite sure where they are covered and where they are not.

Ms. **Kilmurray**. That is true. You go to the social security office and they give you a little book to tell you what is covered. Then you read through and say this isn't covered and that isn't covered and that isn't covered, this isn't covered. So then they rush out and buy an insurance policy. Then they read that insurance policy and they find still something not covered. They rush out and buy another. The second one covers what they got in the first one.

A supplemental policy may pick up one additional thing; it will drop a couple of others. One will insure you against drug costs; the other one will insure you against dental care; another will insure you against eyeglasses. To get one that will cover everything is very difficult. I think duplicate coverage is very objectionable.

General **Blaz**. Thank you.

Mrs. **Bentley**. May I ask, do you know of any HMO's which cover eyeglasses and everything?

Ms. **Kilmurray**. Well, the particular HMO which I belong to will cover the examination for eyeglasses. They will not cover the glasses themselves, but they will cover the prescription.

Mrs. **Bentley**. Thank you for yielding.

General **Blaz**. Then let me ask a personal question. Is that an Irish name, Kilmurray?

Ms. **Kilmurray**. Yes, sir.

General **Blaz**. I have never seen a name like that.

Ms. **Kilmurray**. It is an unusual name.

General **Blaz**. Good. I am Irish, too. Can't you tell?

Mrs. **Bentley**. That concludes our hearing today. We have a lot of excellent information that the committee will be sifting through and seeing what we can come up with, and firm suggestions on how we can improve health care for the seniors.

I do, at this time, want once again to thank Essex Community College for making their facilities available to us.

Thank you all for coming.

[Whereupon, at 3:15 p.m., the hearing was adjourned.]

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